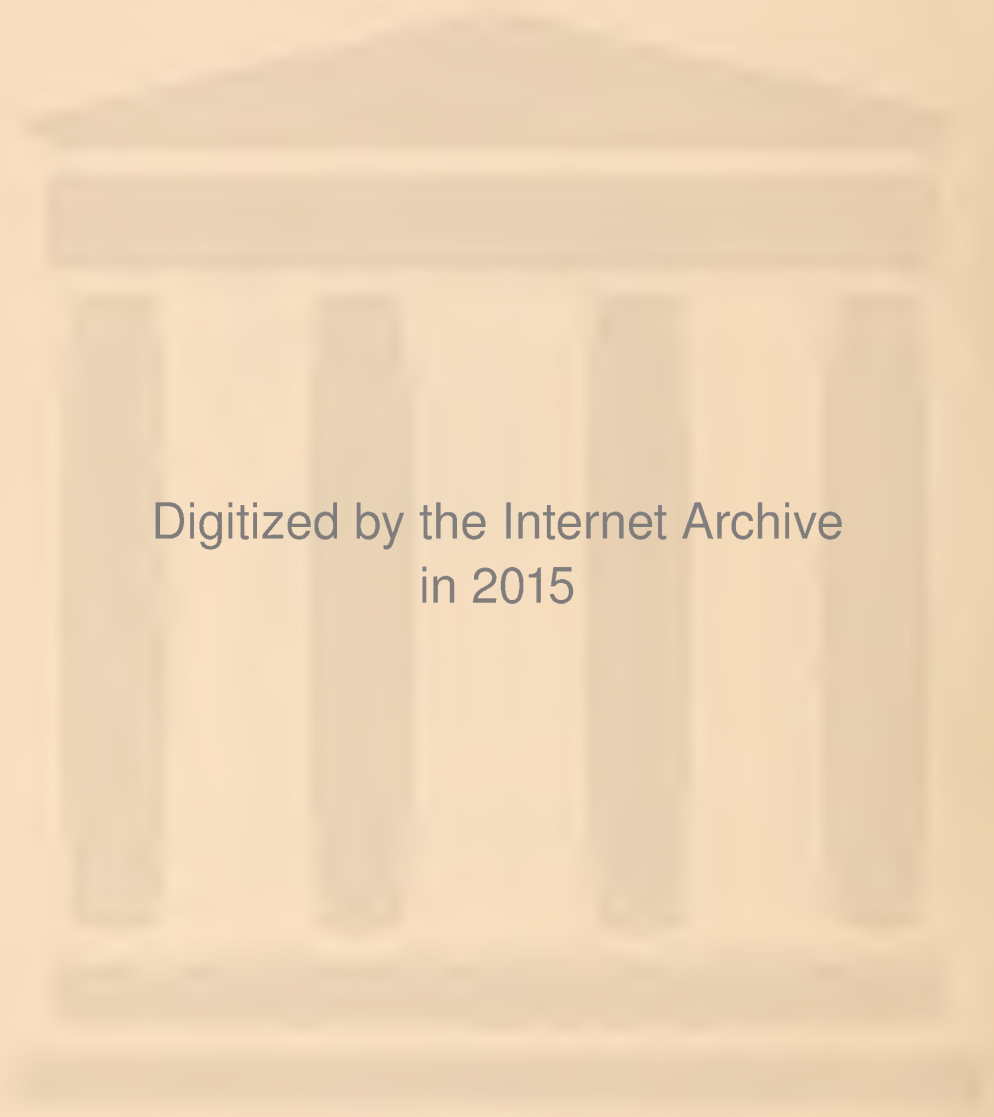
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THE JOURNAL
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VOLUME XIX
NO. 1

Jacksonville, Florida, July, 1932

Yearly Subscription, $3.00
Single Copy, 30c

PHILADELPHIA ACADEMY OF MEDICINE JUL 25 1932 LIBRARY

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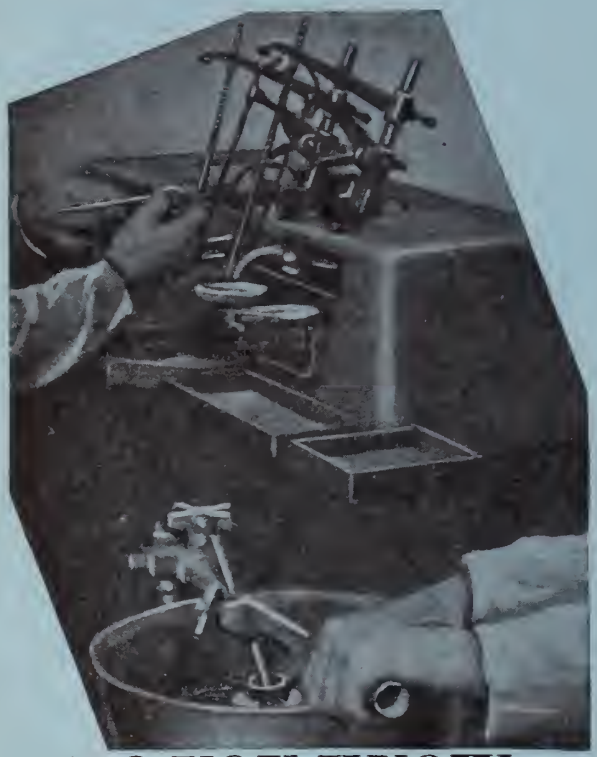
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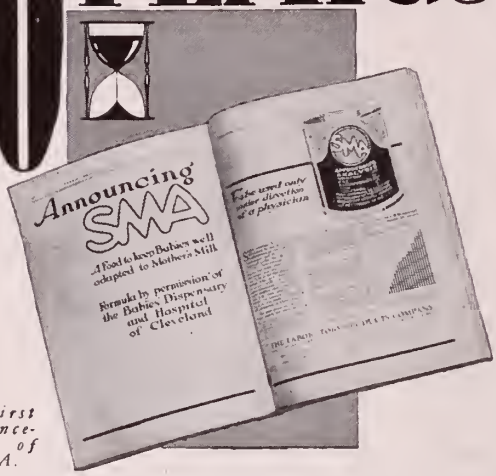
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Volume XXIX | Jacksonville, Florida, July, 1932 | Number 1

CORONARY ARTERY DISEASE AS RELATED TO HEART DISORDERS*

WALTER L. BIERRING, M.D., F.A.C.P.,
Hon. M.R.C.P. Ed.
Des Moines, Iowa.

Of the several classifications of heart disease that have been proposed, the one based on its occurrence in the different age periods, has the strongest clinical appeal.

Heart affections of childhood and the first three decades generally involve the endo or pericardium, are usually of acute rheumatic or infectious origin, and with valvular defects as the most common sequel. In this type the physical signs are of greatest diagnostic importance and constitute the main features of the clinical picture.

In mid-adult life, syphilis is a frequent etiologic factor with the resulting aortitis and associated aneurysm, aortic insufficiency and myocardial disease.

In the later decades of life, arteriosclerosis with involvement of the coronary arteries and associated lesions in the myocardium and vascular hypertension are the most common etiologic conditions concerned with heart disease of that period. The last two types are characterized mainly by the symptoms of pain, angina pectoris, and of myocardial failure. These subjective signs often tell the story before the condition is confirmed by physical or clinical examination.

It is a matter of common knowledge that heart disease is now the leading cause of death, and the mortality curve has been rising steadily for the past twenty years. It is, however, not so generally appreciated that the increasing number of deaths from diseases of the heart occur almost entirely in persons over forty-five years of age, in fact the rate appears to be actually falling in the younger age groups. This is explained as being due, in large measure, to the fact that more people are living to the "heart age", that is, they survive to that period of life when degenerative processes affect the circulatory system to a sufficient degree to cause functional impairment.

*Read by invitation before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

It is with the third or degenerative type of heart disease that this discussion is mainly concerned. This form is largely due to coronary artery disease and accompanied by degenerative changes in the myocardium. It is also, probably, the most common type of heart disease seen by Florida physicians.

The clinical recognition of coronary artery disease constitutes a new chapter in internal medicine, in the development of which American physicians have taken a prominent part. Edward Jenner[1] in the latter part of the 18th century first suggested the probable relationship between calcareous deposits in the coronary arteries and that "disorder of the breast", to which his contemporary, Heberden, gave the name "angina pectoris." Jenner's observations with those of Parry,[2] originated the concept that there was an association between disturbances in the coronary circulation and the manifestations of a disordered heart. In 1884, Leyden[3] gave an excellent description of coronary sclerosis and thrombosis, and for the first time satisfactorily correlated symptoms, signs and pathological changes.

The more definite delineation of the clinical picture has been largely stimulated during the past twenty years by renewed interest in acute coronary obstruction. The historic landmarks in the development of our knowledge concerning coronary obstruction are primarily the account of Leyden, then the report of the Russian clinicians, Obrastzow and Straschesko[4] in 1910, and the publications of James B. Herrick[5] in 1912 and 1919.

As the clinical significance of coronary artery disease has come to be more generally recognized, a new impetus has been given to investigation of the anatomy, physiology and pathology of the coronary circulation. The relation of myocardial infarction to clinical phenomena has been more firmly established, and a clearer conception of the distribution of cardiovascular pain, as well as the significance of changes in the electrocardiogram has greatly widened our knowledge of the problem.

The blood supply to a tissue is often a key to

the understanding of pathologic processes which may occur in the same, and the study of the coronary circulation has been further stimulated by the constant endeavor to correlate it with clinical phenomena incident to coronary artery disease.

Recent anatomic studies have developed some interesting facts. The coronary blood supply is very diffuse, penetrating to all parts of the myocardial tissue, and showing considerable variation in distribution, collateral anastomosis and at different age periods.

Oberhelman and LeCount[6] maintain that some of the difficulty in understanding coronary disease of the human heart is directly attributable to a general disposition to regard the coronary arteries and their entire arterial bed as an anatomic "invariable," whereas such is not the case. This they verified by the examination of twenty-six human hearts, mostly from males between the ages of fifteen and seventy years. The hearts were injected with metallic mercury through a cannula tied in the mouth of one coronary artery.

In one group of nine hearts with no demonstrable myocardial disease or arterial changes, both arteries had to be injected separately to fill the arterial system. Another group of five hearts with no myocardial or arterial disease showed definite collateral anastomosis because the entire arterial system filled through the mouth of one artery. In a third group of twelve hearts with diseased arteries, almost or total occlusion of one or another coronary occurred, with extensive myocardial changes, yet had abundant demonstrable collateral circulation.

This confirms previous observations by Galli[7] and Merkel[8] that the gradualness of occlusion of a coronary artery was important for the development of an adequate collateral anastomosis. An arteriosclerotic heart will withstand an acute occlusion better than where a previous gradual narrowing of the coronaries has not taken place.

Barnes and Whitten[9] have demonstrated a significant difference between the right coronary supplying the right ventricle, and the branches of the right and left coronary arteries supplying the left ventricle. The branches which supply the left ventricle do not spread out in a general plane, but instead leave at right angles and penetrate straight through the myocardium, giving off very few branches until they reach the endocardium, where they again turn at a sharp angle, and end in a mass of fine arterioles. By the anchoring of these branches, it can readily be assumed that in conditions of hypertrophy of the left ventricle, as following hypertension, the blood vessels become elongated and tortuous, leading to narrowing, twisting and occlusion of the lumen through endarteritic changes.

The studies of Wearn [10] of the capillaries and the role of the thebesian veins in the circulation of the heart constitute an important addition to our understanding of coronary artery disease. The rich blood supply of the average heart is largely due to the abundant capillary bed, it being estimated that the number of capillaries per square millimeter of ventricular wall or papillary muscle is about twice that found by Krogh[11] in skeletal muscle. The same author presents evidence that there is a direct connection through the thebesian veins, other than through the capillaries, between the coronary arteries and the chambers of the heart, so that in the event of gradual closure of the orifices of the coronary arteries, the thebesian vessels can supply the heart muscles with sufficient blood to enable it to maintain an efficient circulation. There are thus definite anatomic reasons for the variable effects resulting from gradual or sudden coronary occlusion.

The coronary arteries are subject to various pathologic changes such as—atheroma, atherosclerosis, syphilitic arteritis, and the different chronic endarteritides, all of which produce a gradual obstruction of the artery. Sudden obstruction is due to thrombosis, less often to embolism. While the definite cause of arteriosclerosis is not established, diabetes mellitus and those conditions leading to vascular hypertension are recognized as prominent factors in producing coronary artery changes.

Acute rheumatism, so common in the etiology of valvular heart disease, plays a minor role in coronary artery disease. Syphilis is concerned in only five to eight per cent of the recorded cases.

Interference in the coronary circulation, partial or complete, has long been known to lead to pathologic changes, particularly infarction of the myocardium, and in some instances produced death.

Weigert[12] in 1880 was the first to expound the doctrine of cardiac infarction, and establish the complete analogy between coronary infarction and the same process in other organs. In the same year Zeigler[13] introduced the term "myomalacia cordis." This has also been called fibrous myocarditis and represents a series of infarctions replaced by fibrosis, which gradually produce

dilation and myocardial failure. This inter-relation of coronary occlusion and myocardial ischionecrosis has been supported by numerous pathologic and clinical reports. The experimental obstruction of the coronary arteries as carried out by Miller and Matthews,[14] Karsner and Deweyer,[15] Smith,[16] Wearn[17] and others, developed definite infarction similar to those observed in human hearts. The extent of the infarction varies from very small (almost microscopic) areas of necrosis and fibrosis to those involving a large portion of the ventricular musculature. The apex is a frequent site, and the left ventricle is involved more often than the right.

With such a pathologic background of myocardial infarction, it is possible to correlate some of the characteristic clinical phenomena incident to coronary occlusion. A large infarction suddenly produced readily explains the various phenomena of shock, the sudden drop in blood pressure, muffled heart sounds, and relaxed peripheral circulation, followed later by leucocytosis and fever. If the infarction area can heal by replacement fibrosis, a fair degree of cardio-circulatory balance can be maintained for years.

Until within the last two decades the concept of coronary occlusion and cardiac infarction as a clinical entity was regarded among the rarities in medicine.

The distinction between angina pectoris and coronary thrombosis is also of recent development. We are indebted to Osler[18] for the first real correlation of the clinical and pathological findings of angina pectoris presented in his Lumleian Lectures in 1910. He discussed angina pectoris as a disease entity, as to its incidence, etiology, pathology, and clinical records, which strikes a familiar note in comparison with the descriptions of coronary occlusion of this later period. Osler referred to angina pectoris as a "disease characterized by paroxysmal attacks of pain, pectoral or extra pectoral, associated with changes in the arterial walls, organic or functional." He proposed a classification into three clinical types of very mild, mild, and severe forms, with subdivisions into acute and chronic types, that bears a strong resemblance to the classification proposed by Herrick for the different types of coronary occlusion.

It is evident that the cases which we now recognize as acute coronary thrombosis were formerly regarded as instances of severe angina pectoris, or status anginosus. Furthermore, the chronic form of severe angina described by Osler with frequent recurring attacks over a period of years can well be compared to the gradual narrowing of the coronary arteries by endarteritic changes producing finally complete occlusion.

The first important publication of the clinical features of coronary thrombosis appeared in 1910 by two Russian observers, Obratzow and Straschesko. Two of their three cases were correctly diagnosed antemortem, and all three cases had precedent angina pectoris. They called attention to most of the clinical features now recognized as important symptoms in coronary thrombosis.

In 1912 Herrick published his first interesting article in which he emphasized the fact that coronary thrombosis was a clinical entity, could be recognized during life, and that it need not end fatally. His careful observations and persistent efforts have done much to focus the attention of the American medical profession on this disease. Since then have appeared further reports by Herrick, as well as those of Pardee,[19] Paullin[20] Longcope,[21] Wearn, Willius, and Brown,[22] Christian,[23] Scott,[24] and Conner and Holt,[25] indicating that it cannot be classed as a rare disease in this country. Herrick in 1919 proposed a very appropriate classification of the clinical forms under the following four types:

(1) Cases of instantaneous death in which there is no death struggle, the heart beat and breathing stopping at once.

(2) Cases of death within a few minutes, or a few hours after the obstruction. These are the cases that are found dead, or clearly in the death agony by the physician who is hastily summoned, and both forms are often first seen by the coroner.

(3) Cases of severity in which, however, death is delayed for several hours, days, or months, or recovery occurs.

(4) A group that may be assumed to exist embracing cases with mild symptoms—for example, a slight precordial pain ordinarily not recognized, due to obstruction in the smaller branches of the arteries. This type, also, resembles the chronic form described by Osler as a subdivision of severe angina.

The third type probably represents the form for which a typical clinical syndrome has been established, and is now readily recognized. The clinical phenomena are subject to considerable

variation, depending in a large measure on the extent of myocardial damage.

Acute coronary occlusion is attended by two definite clinical manifestations, viz., severe angina or status anginosis, and the symptoms of shock and collapse, with the attending phenomena of pericardial friction, leukocytosis, fever, and different forms of congestive heart failure.

Pain is the outstanding and most characteristic symptom of acute coronary occlusion. It is more severe and prolonged than ordinary angina, and corresponds to the term status anginosus used by Allbutt and the older writers. The onset is usually sudden, and again may be gradual, extending over several days before becoming severe. It constitutes the "angina of rest" in that it usually occurs while at rest, at the table, or the patient may be awakened at night by terrific distress. In many cases there is previous history of chest pain, but the patient recognizes a distinct difference in that the pain of occlusion is much more severe, agonizing, boring or cramp-like. It has a greater tendency towards the lower sternum and upper abdomen, and usually extends more laterally.

While the pain is usually continuous, the intense manifestations often come and go in a wavelike manner. In addition to the severe angina the patient appears in a state of shock as shown by the cyanotic pallor, and ashen-gray color of the skin, profuse perspiration, a pulse of small volume and a rapid drop in blood-pressure, often from a systolic pressure of 180 to 200 millimeters to as low as 100 millimeters; this fall may continue for hours or several days. The heart sounds are weak and muffled, the first sound at the apex may become inaudible. As a part of sudden heart failure a pulmonary edema frequently develops which may be followed by other expressions of visceral congestion. The pain gradually diminishes after several days, but the patient continues to feel very weak and exhausted.

Dyspnea may develop early and is sometimes a more prominent symptom than the pain. In a measure it represents a response of the myocardium to the extent of infarction, and varies from a shortness of breath, a Cheyne-Stokes' breathing, to the awful struggling respiration of cardiac asthma.

A pericardial friction rub is occasionally heard, particularly with infarction near the pericardial surface, and often constitutes the only distinctive physical sign of cardiac infarction. It is rather transient, heard usually between the second and fourth day, and ordinarily disappears entirely after one or two days. Leukocytosis, first described by Libman and Sacks,[26] with fever, is an important symptom, and may be regarded as a characteristic response or reaction of the cardiac infarction.

Acute indigestion represents a common form of onset in the popular mind of coronary occlusion, an nausea is often a distressing symptom, particularly during the attacks of angina. There is a frequent urge on the part of the patient to relieve the nausea by vomiting, as well as a desire to go to stool.

Herrick directed special attention to the epigastric reference of the pain with the frequent nausea, and vomiting, because it often suggested to patient and physician some abdominal accident, as acute pancreatitis, perforation of the gallbladder, or a gastric or duodenal ulcer. The additional signs of leukocytosis, fever, increased muscular spasm, contact with acute surgical conditions, as described by Levine and Tranter,[27] Gorham,[28] Willius, and Hamburger,[29] when combined with the symptoms of shock and collapse tend to greatly strengthen these suspicions.

The course and outcome of acute coronary occlusion vary greatly. Some patients seem to improve, then expire suddenly during an attack of angina; others gradually develop the clinical picture of congestive heart failure, and succumb after an illness of several months. Of those who recover a certain number are required to limit their activities to avoid a recurrence of anginal distress, but within recent years in a number of instances where the victims were among our leading physicians an apparently complete symptomatic recovery has taken place.

The fourth, or milder type of Herrick, corresponding to the chronic form of angina as classified by Osler, is characterized principally by the recurrent symptom of pain or angina pectoris.

This represents the "angina of effort" as distinguished from the "angina of rest" occurring in acute coronary occlusion. It is now assumed to be associated with a narrowing of the coronary artery or thrombosis of one of the smaller branches. The tendency is for the attacks to recur with greater frequency, particularly with physical strain and effort, and to terminate as a final coronary occlusion or thrombosis.

The clinical picture of coronary occlusion has now become so clearly defined as to permit its

ready diagnosis without difficulty. Because of its wider recognition and extensive investigation of the problem, interesting studies have been developed with regard to the distribution of cardiovascular pain, and the significance of electro-cardiographic changes, which will be discussed briefly.

The time has not arrived for a definite opinion as to the origin and nature of the pain in angina pectoris. Two theories have prevailed for several decades, the aortic and the coronary, of which the latter is gaining more adherents among present day clinicians.

The observations made in connection with acute occlusion of the coronary artery have tended to strengthen the view that the paroxysm of pain of angina of effort has its origin in a perversion of function of the coronary artery or the muscle supplied by that artery or both. Sir Thomas Lewis[30] regards the muscle ischemia as the essential factor in producing the pain. He contends that the most powerful argument for the theory that anginal pain is caused by muscular ischemia is the symptomatology of acute coronary occlusion.

Assuming that the origin of pain is connected with the heart muscle, the nerve supply of the heart and its coverings as related to that of other viscera and adjacent tissue become an important factor in understanding the distribution of cardiovascular pain.

The pain associated with coronary disease has the same characters as those which feature the reflex pains of visceral disease, in that (1) it is often remote from the site of irritation and (2) it follows lines on the skin of the spinal segmentation rather than the course of the peripheral nerves, and (3) it is usually associated with cutaneous hyperesthesia and tenderness to pressure.

A painful stimulus arising in the heart is conveyed by an afferent sympathetic nerve to the spinal cord. On reaching the cord the abnormal stimulus spreads beyond the sympathetic center and affects nerve cells in its immediate neighborhood. The cells so stimulated react according to their function, the sensory causing a sensation which the brain recognizes as pain, and refers to the peripheral distribution of the sensory nerve in the skin or muscles, the motor nerve producing contraction of the muscle.

The pain and feeling of constriction about the chest in angina pectoris and coronary occlusion can be explained in this way. Aside from the reflex pains connected with the sympathetic nerve supply, the vagal sensory reflex is involved through stimulation of the vagus. As its center in the medulla is in near relationship to the upper cervical nerves, particularly to the nerves supplying the sternocleidomastoid and trapezius muscles, these muscles often become extremely hyperalgesic in various heart affections but the pain may also be felt in the further distribution of the cervical nerves over the shoulder and arm area.

As a result of reflex stimulation of the floor of the fourth ventricle, an abundant flow of saliva, and the secretion of large quantities of pale urine may occur. There are also good reasons for attributing some forms of dyspnea and possibly nausea and vomiting to reflex stimulation arising in the heart.

A further interesting explanation of visceral pain is offered by the study of the development of the diaphragm and accompanying distribution of the phrenic nerve.

According to Mall[31] the "anlage" of the diaphragm lies in the head region of the early embryo together with those of the heart and liver as well as the three embryonic body cavities, the pericardium, pleurae, and peritoneum, which descend to their anatomic position during the process of development.

It will be noted that the diaphragm wanders from the head region to the abdomen, passing by, as well as modifying structures and organs along the way.

The phrenic nerve arises in the cervical region in close connection with the third, fourth, and fifth cervical nerve roots, and enters the anlage of the diaphragm. As this organ descends, the phrenic nerve lengthens to give it innervation, and is distributed during its downward course to the pericardium and covering tissues of the heart, the upper and lower surfaces of the diaphragm, the upper epigastrium, suspensory ligament and surface of the lower, and suprarenal capsule region. It also communicates with the diaphragmatic plexus as well as the semilunar ganglion of the solar plexus.

Very suggestive in this connection is the interesting publication of Oehlecker[32] on spontaneous shoulder pain in connection with inflammatory conditions of the upper abdomen involving the diaphragm; and that of Capps[33] on experimental study of the pain sense in the pleural membranes.

A clinical study of phrenic shoulder pain by Zachary Cope[34] and the importance of phrenic

shoulder pain in disease involving the diaphragm by Orr[35] are all interesting contributions to the subject.

As left shoulder pain occurs in abdominal diseases involving the diaphragm and phrenic nerve, so also, may pain arising in the heart area be referred to the epigastrium and upper abdomen. With the above in mind the diagnostic interpretation of referred pain in angina pectoris and coronary occlusion is given a more logical explanation.

By furnishing certain graphic demonstrations of coronary disease and its effects on cardiac structure, the electrocardiograph has added valuable diagnostic information. As confirmatory evidence to be correlated with clinical findings it has proved of greatest value.

The clinical recognition has been greatly advanced by American internists who recognized that certain electrocardiographic changes were characteristic following acute coronary obstruction. By continued serial observations of subsequent changes in the electrocardiograms further definite characteristics have been established. These changes are largely concerned with the end of the ventricular phase, the so-called QRS complex and the T wave.

In 1920 Pardee reported an electrocardiographic sign of coronary artery[36] obstruction which he regarded as having diagnostic significance. This sign consists of a particular deformity of the R-T segment in which there is a sharp take-off from the descending limb of the R wave followed directly by a sharply inverted T wave, thus obliterating the usual R-T or S-T iso-electric interval. This has been confirmed to a large extent by the observations of Herrick, Smith, Willius, et al., and particularly by the serial records published by Parkinson and Bedford[37] and more recently by Cooksey and Freund.[38]

This apparent constancy of T wave changes following coronary occlusion and cardiac infarction appears to uphold the idea first expressed by Pardee that when muscular tissue of the heart is diseased there will follow abnormal variations in electrical currents due to the heart's contraction.

The negative T wave may be regarded as a fairly constant sign of previous coronary occlusion and cardiac infarction. It, therefore, seems reasonable to assume that obstruction of the coronaries may develop gradually by the narrowing of the lumen of a vessel from arteriosclerosis, and lead to a similar area of degenerative muscle as is found some time after acute occlusion by a thrombus, and that such a condition can present the negative T wave and other recognized electrocardiographic signs.

As Willius states, the almost constant occurrence of T wave negativity in coronary thrombosis is the most important evidence that links this characteristic with obliterative coronary disease.

The occasional failure to obtain characteristic electrocardiograms in definite clinical cases of acute and chronic coronary occlusion has led some clinicians to question their diagnostic significance.

As further records are presented of electrocardiograms taken at frequent intervals, the constancy of characteristic changes will be more generally recognized. On the other hand, the electrocardiogram will occasionally reveal changes indicative of coronary artery disease where the principal clinical signs are lacking.

Careful records, frequent observations in each case, and constant correlation with clinical phenomena will establish electrocardiography as a helpful adjunct in the diagnosis of coronary artery disease.

Treatment.—The new conception of coronary artery disease has influenced the therapy of the condition to a considerable extent, with distinct progress in the relief of its symptoms. The outstanding symptom in acute or chronic coronary disease is pain, and there is a general recognition of the debt to Lauder Brunton[39] for his discovery in 1867 of the nitrites in the treatment of angina. While in no sense curative, the vasodilation produced has a distinctly soothing effect and is a boon to the sufferer with periodic angina.

A different consideration must be given to the prolonged angina or status anginosus incident to acute coronary occlusion with the accompanying signs of shock and collapse as indicated by the sharp fall in blood-pressure, the cold, clammy skin, and extreme exhaustion.

The severe and ofttimes excruciating pain of status anginosus requires the hypodermic use of morphin in one-half grain doses, and it may be necessary to repeat this dose several times before relief is obtained. This relief of pain is very necessary in order to properly carry out the important essential, that of rest, which should be as complete as possible.

A recent report by Rizer[40] of the use of oxygen

inhalations for the relief of coronary occlusion pain is very encouraging. In a series of its use in 30 cases the pain was relieved as promptly as with morphin. This seems a logical procedure in view of the prevailing conception that muscular ischemia is the principal factor in anginal pain.

Special nursing is necessary, and the patient should not feed himself for several days. Exertion incident to the use of the bed pan should be guarded most carefully, and it has happened that a patient in attempting to go to the toilet has died during the effort.

The application of digitalis is dependent upon the development of signs of myocardial failure such as dilatation, pulmonary edema, or further indications of visceral congestion. There are occasions soon after the onset of the coronary occlusion where the judicious use of digitalis has given most striking results.

After the acute symptoms of occlusion apparently subside further indications of cardiac failure with visceral congestion may develop for which again the use of digitalis and other appropriate measures are indicated.

The length of time that rest in bed should be continued will vary in different cases, but it is generally agreed that the minimum period should be six weeks, followed by a similar period of very restricted activity.

The management after the patient is allowed out of bed is deserving of careful supervision. Graded exercises have an important function at this stage, and all activities should be carefully regulated, so as not to extend to the point of shortness of breath or recurrence of anginal pain.

In conditions of well-established coronary disease as indicated by recurrent attacks of exhaustion, dyspnea, angina with effort, and characteristic electrocardiographic changes a distinct advance has been made in the better appreciation of the pharmacologic effect of certain drugs that promote an increased coronary flow.

The experimental ligation of the coronary arteries in dogs by Smith[41] and others, as well as the observations on man following occlusions of these vessels, has demonstrated that the heart is extremely sensitive to the reduction of its blood supply. It is further recognized that a knowledge of the factors concerned in the regulation of the coronary circulation has an important bearing on a better understanding of impaired cardiac function.

The experiments of Smith and his co-workers indicate that the rate of coronary flow is greatly altered by the change in diastolic pressure, and the maintenance of an efficient coronary circulation is fundamentally dependent upon the height of the diastolic pressure. Drugs which promote a greater coronary outflow appear to increase diastolic pressure.

The experimental work of the action of drugs like theophyllin and its derivative euphyllin has formed a logical basis for the therapeutic use of these preparations in the human person affected with coronary artery disease. Euphyllin or metaphyllin, as well as amidophyllin, is administered in doses of one and one-half to three grains three times daily, and may be used over a long period of time; these drugs are quite harmless, as a personal observation of its use in one patient for two and a half years did not show any undesirable effects.

Theobromin may be employed and recently theocalcine has been highly recommended.

The manner of the diuretic action of these drugs is still undetermined. To what extent they promote an increased rate of coronary flow is also difficult to determine clinically. After their use in a considerable number of cases, the impression is gained that the angina and other cardiac discomfort is distinctly relieved. No doubt the elements of rest and restriction of activities are also factors to be considered. A sedative such as phenobarbital is often of benefit. For recurrent angina pectoris where the patient is confined to bed, the administration of nitroglycerine, as suggested by White, taken four or five minutes before some necessary effort, has distinct prophylactic effect.

In recent years various surgical and injection procedures have been introduced for the treatment of angina pectoris. Cervical sympathectomy was introduced by Jonnesco in 1916 and has had a limited application in selected cases. It seems a rather formidable operative procedure in patients with coronary artery disease and disagreeable after effects frequently follow it.

A much simpler procedure is the production of sympathetic block by the alcoholic paravertebral injection of the upper thoracic posterior nerve roots which gives relief in approximately 50 to 75 per cent. It is apparently free of most of the ill effects of operation. Since this procedure affords only sympathetic relief, the patient must be followed by continued care to avoid unneces-

sary strain, as the warning signal of angina may have disappeared.

The treatment of each case of coronary disease is more or less an individual matter, and it is, therefore, difficult to propose definite regulations applicable to all instances.

It is, however, well established that a recovery from the acute manifestation of coronary occlusion is possible, and life may be prolonged even beyond ten years. In some instances complete recovery, as far as all subjective clinical symptoms are concerned, has been reported by careful observers.

In conclusion it is interesting to recall that the knowledge that has developed in regard to the coronary artery and its relation to heart disease during the past two decades is largely the result of careful studies and investigations by American clinicians.

With all this accumulated knowledge, much remains unsolved, the unknown factors being more concerned with the pathological background than in its clinical expression. When the cause of arteriosclerosis and hypertension is better understood, we shall have advanced still farther in our knowledge and prevention of coronary artery disease.

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HAY FEVER IN FLORIDA*

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It is not my intention today to deal with the various theories as to the pathological nature of the reaction which takes place upon the part of the nasal mucous membrane and which gives us the well-known symptom complex called hay fever or allergic rhinitis. I shall endeavor, therefore, to confine my remarks to the extrinsic causes of this condition, and their prevalence and distribution in Florida, in the light of our present, rather incomplete, knowledge.

The most reasonable and logical concept as to these causes and their mode of action is, in my estimation, that which was presented to me by Cohen of Cleveland. For the purpose of this paper, I shall mention only certain of its salient features.

This concept classifies the causes into two groups, one called the specific exciting causes, which includes all foods and all inhalents. Members of this group can and do cause allergic reactions unaided by any other substance or condition.

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Assn., Sarasota, May 3, 4, 1932.

The other group is designated as non-specific, exciting causes, or in other words, factors which aid and abet the specific cause but which in themselves rarely, if ever, are the sole cause of an allergic reaction. They include thermal, mechanical, chemical, infectious and neurogenic factors.

This chart or concept recognizes a tolerance point in allergic individuals to their allergen or allergens and it is the exceeding of this tolerance point which throws the individual into what is termed allergic shock, or the point at which reactions occur sufficiently severe to cause symptoms.

It is this shock, manifesting itself on the part of the nasal mucous membrane and commonly called hay fever, with which we shall deal.

Hay fever may be divided, for purpose of discussion, into two classes, the seasonal variety and the annual variety. The seasonal variety, as the name implies, comes on or recurs at a certain season each year and lasts approximately the same length of time every year. The specific exciting cause is usually the pollen of some tree or plant which, within reasonable limits, pollinates at a certain time each season.

It is in this field of allergy that we have encountered the greatest difficulties.

One pollen and plant survey was made in Miami in 1929, but if any others have been made elsewhere in the state, I have been unable to find them. It is obvious that to even approach thoroughness in this work, it is necessary not only to know what pollens float in our air and when they are there, but one must secure a quantity of these pollens for test and treatment sets. The seasonal hay fever problem is strictly a local one, in that plants vary in different locations not only in kind but in numbers, and concentrations of air-borne pollens have a direct bearing upon treatment.

Finally, I secured the aid of a competent botanist, Mrs. Miles of Tampa, who not only gave me an accurate list of our air-borne pollens but gathered a quantity of each, as they pollinated last season, especially those which grew in greatest profusion and which we therefore suspected of being the greatest pollen spreaders.

At this point Dr. Cason of Jacksonville referred me to the chief botanist of Abbott Laboratories, Mr. O. C. Durham, and there also I struck a gold mine. Through his efforts and a little help from myself, surveys have been made in Tampa, Sarasota, Arcadia and Jacksonville and some interesting facts brought to light. An analysis of these findings shows the following important points:

Ragweed, being the chief offender, our efforts were first directed toward learning about its distribution and season. The west coast of Florida is now undergoing the sad experience that many of the Michigan hay fever resorts had, namely, that with increased population and cultivation, ragweed has been accidentally introduced or more favorable conditions created for its growth. Whichever reason is the correct one, the fact remains that since I have become weed conscious, I notice each year a definite increase in ragweed; along the shoulders of our roads—in the ditches; extending over into the fields and in abandoned yards and cultivated fields. An important and apparently contradictory fact was brought to light in regard to its season of pollination. Ragweed today is up and about two feet high here, while in my native state of Ohio, I doubt if it has started yet. But ragweed pollen appears in Ohio in the air as early as the third week in July, whereas here the first appreciable amount appeared in Jacksonville August 20th and not until August 27th in Tampa or Sarasota. The season in the north ceases abruptly with the first heavy frost, while in Arcadia pollen was found as late as November 9th.

Miami has practically no ragweed; certainly, judging from the surveys, not sufficient to cause any symptoms or pollinosis. I presume the same statement would apply to all the east coast cities, especially in south Florida, but since I have no available information or counts upon which to base such a statement, it must temporarily remain uncertain.

Jacksonville has a small count, whether sufficient to cause symptoms or not it would be impossible to state, as the minimum amount necessary is at present not known. Sarasota, Arcadia and Tampa, however, sad as it is to relate, do have sufficient to cause trouble and, as I have said, I believe it will show an increase each year. Counts here run as high as forty-one granules per square centimeter per day and I believe the fact that I have treated many cases of seasonal hay fever in 1931, successfully, by desensitizing them to ragweed alone, rather proves that a sufficient amount of pollen is present to cause trouble. Alternating sea and land breezes, however, in the coastal cities, made the counts resemble a septic temperature chart.

Among the other pollens found were grass, chenopods, tree, composites and some unknowns.

The annual variety of hay fever, or allergic rhinitis, is, in my experience, much more prevalent in southern Florida than the seasonal variety. The causes are those which, like "the poor, ye have always with you." The chief offenders are orris root, house dust, animal epidermals and occupational dusts. However, to complicate this situation one or more foods aid and abet the chief criminal, or may themselves be the exciting causes. It is therefore necessary to investigate all the foods in addition to the inhalents and eliminate those found guilty. Then to add to the misery of both the victims and the allergist, this type is frequently complicated by sinus infections, due to prolonged congestion of the mucous membranes and consequent lack of proper drainage of the sinuses. Polypi often help swell the crowd and, incidentally, the nasal passages.

So the problem of clearing up a case of long standing annual hay fever is best accomplished by the allergist working with a competent nose and throat man. Neither can accomplish the best results working separately, especially as the time element, for surgical interference, is such a vital one.

The methods of investigation to determine the allergin responsible in each case, I shall simply mention and not elaborate upon. The chief ones are: the scratch test, intradermal, contact, elimination diets, filtered air and the conjunctional test. I employ them all, preferring the intradermal, but when using pollens, this method is never used until after a scratch test has been done. This scratch test should, and in most cases does, eliminate much of the danger of obtaining a violent reaction upon intradermal use of that pollen. A big positive scratch test obviates the necessity for the intradermal, and warns one to use a very high dilution as a starter for obtaining his threshold intradermal reaction necessary for starting treatment.

Treatment consists of removing the offending substance or substances from the patient or the patient from them. When this is not feasable, desensitization must be done. It will be frequently found that desensitization to only one inhalent will place the patient in the balanced allergic state although tests may show sensitization to more than one substance. If this happy circumstance does not result, the first solution should be kept up and the patient desensitized to the other or others. As I have said, the services of a nose and throat specialist are necessary in many cases.

To neglect or discount the various other adjuncts to treatment, such as the inhalation of CO_2 gas, the use of astringent nasal packs and inhalents, a reduction of the alkali reserve, the use of ultra-violet ray treatment, and others, is to invite failure in many cases and lower the percentage of good results obtainable. All of these methods have their uses and values and in selected cases should be employed.

In the light of our present knowledge, it is to be hoped that our State may in the future escape the unjust criticism accorded it by misinformed sufferers from both hay fever and asthma, who are sent to Florida and assured that the change of climate will cure or keep them symptom-free, and who continue to suffer here, or obtain very little relief. One cannot blame these people, but they should not blame the State or climate.

Florida has many advantages, possessed by few places in the United States, for the sufferer, but before a change of climate is made, a thorough allergic investigation should be made of the individual in question. Taking into consideration his specific exciting cause, it is obvious that if he is a ragweed victim, Miami and vicinity is excellent. If his cause is an inhalent present in houses, he would obtain fewer hours of exposure to these substances in south Florida, simply because our climate enables him to stay out of doors more. And the non-specific exciting causes such as sudden changes in temperature, extreme cold, irritating gases from manufacturing plants, etc., are largely absent from our environment.

It is likewise obvious that the sufferer from food allergy will obtain no relief here, nor will the hay fever or asthma case who brings with him his allergen in the shape of a pet dog or cat.

So it is up to us to gather more facts, and to present them to the doctors so that in the light of real knowledge the sufferer may receive advice as to climate and what to expect from it which will be really worthwhile.

DISCUSSION

Dr. E. Sterling Nichol, Miami:

I want to congratulate Dr. Metzger on his interesting paper. We can not expect any brief paper to cover any more than the high points of a subject of such dimensions as "allergic rhinitis." There are a few things that I would like to ask

Dr. Metzger, however, that I did not get from his paper.

In discussing the botanical survey he mentioned ragweed, but I did not hear him mention any other pollens. In our survey in Miami two or three years ago we found that bermuda and natal grass were the most important pollens. Ragweed played a very small part. I would like to know what grasses have been found on the west coast, and how important he feels they are.

The whole question of allergic rhinitis is such a befuddled one in the minds of the great majority of men who practice medicine because so much false reasoning takes place due to the interplay of the specific and non-specific causative factors.

Now, if a physician has no means of detecting the allergic factors, and one can not do it by making a few scratch tests, if he has no means of making a true investigation, then he should attempt to rid the patient of the non-specific excitants. It strikes me that unless a man wants to send his patient for a thorough allergic study somewhere or become sufficiently interested himself to work out the allergic problem completely, he had better leave allergy alone and try out the non-specific methods of treatment.

Just one more point I would like to bring out, not mentioned by Dr. Metzger, and that is, when to seek the cooperation of the nose and throat men in these cases. The question is when to do nasal surgery. If there are any nose and throat men here, I am sure they have all had the experience of doing nasal surgery in these allergic cases at a time when the symptoms were ripe, and saw their patients go through a much more stormy postoperative period than if they had waited for a time when the patient was in a "balanced" state and free from symptoms.

The question of relation to infection was not brought out very definitely in Dr. Metzger's paper due to the lack of time. I think the most rational viewpoint is that expressed by many allergists and oto'aryngologists who have been associated with allergists in their cooperative studies, and which has been brought out particularly by Dr. Hansell of St. Louis. Through a study of the histopathology of the nose in the presence of allergy, he has been able to show that the allergic factor is the primary thing and that the infection comes along usually as a secondary manifestation. Due to sensitization the mucous membranes of the nose and sinuses are edematous and that, in turn, tends to produce a gradual formation of polypi. Then because of the poor drainage, infection is more prone to occur, and when it does take place, the problem of treatment becomes aggravated.

Dr. B. W. Lowry, Tampa:

It has been conservatively estimated that from 1½ to 2% of the population of the United States suffer from hay fever. Of this number approximately 65% will finally become asthmatic during some period of their lives. It is therefore of the utmost importance that more scientific study should be devoted to this distressing condition that is so prevalent in all tropical and temperate climates.

Until recently, Florida has been one of the few states in the Union that has not conducted a thorough and complete survey of its botanical flora. This important work of studying and identifying the common grass and tree pollens belongs to the field of allergy and botany and I am certainly glad to learn that a real investigative effort along these lines is being carried out in different sections of our state. A complete list of these pollens should be in the hands of all general practitioners, pediatrists, internists and rhinologists, as we now know that practically all seasonal hay fever and a large percentage of perennial hay fever is due to the action of one or more of these pollens.

The successful treatment of the two types of hay fever (seasonal and perennial) requires the closest cooperation between the allergist and rhinologist. The histopathologic changes in the allergic nose are similar to those found in the bronchial tissues in bronchial asthma, namely, thickening of the surface epithelium; edema and infiltration of the subepithelial spaces with eosinophiles, plasmic cells and lymphocytes. In severe cases of allergy the edematous tissue may go on to the formation of polypi usually seen in the region of the middle meatus and maxillary sinuses. This swelling and edema of the tissues make hay fever victims unusually prone to develop pathology of an infectious nature in the paranasal sinuses, thereby aggravating the symptoms and complicating the treatment generally. It is therefore evident that all hay fever patients should have a thorough intranasal and sinus study by a competent rhinologist to ascertain to what extent complicating pathology exists.

It has been my experience that local intranasal treatment of a medical nature such as ephedrin, cocain, cautery and tampons is purely palli-

ative. I am also inclined to be very conservative in doing surgery of a radical nature in these cases. Occasionally a submucous resection—removal of obstructing polyp or drainage of an antrum—will make the patient more comfortable and assist the allergist in obtaining results. Removing middle turbinates and ethmoid exenteration are indicated only in the rarest of cases, as I believe it makes the patient more liable to develop bronchial asthma. This region of the nose has an important function to perform in filtering and preparing the impaired air thereby protecting the already hypersensitive lower respiratory tract. This statement of course does not apply to suppurative ethmoiditis.

Unless the rhinologist has a wide knowledge of the subject of allergy and is prepared to search for the real causative factor of hay fever he is doomed to failure in its treatment. The average nose and throat man is entirely too busy with other problems to be proficient also in allergy, and I am of the opinion that any community having a well-trained and competent allergist is fortunate indeed. He can be of the greatest assistance to the general practitioner, pediatrist and internist who are usually the first to see these unfortunate people.

Dr. T. M. Rivers, Kissimmee:

I just want to call your attention to the fact that there are too many points overlooked in the treatment of all of these allergic conditions. In the first place we want to consider the sensitizing agents, and when we think of the fact that there are some five hundred sensitizing agents of various kinds, it is sometimes hard to get away from them. It may be the paint on the wall, or someone may be using wall paper. It may be the rug, the curtain or a dog, cat or canary bird, or all of these things. It is hard to get away from these things. Then again, some one mentions the respiratory abnormalities, and that is very well. It is necessary to get away from these things or get them corrected. And then someone mentions infection. Yes, that is another cause. We want to correct that.

But the most important point in all of these allergic conditions is the idiosyncrasy. We find that a great majority of these people who are allergic have low blood pressure. And if the blood pressure is subnormal what we want is to build up the ability to resist. We treat most of these cases as we would treat a tuberculosis case. Build up their resistance against things. These agents seem to act through the parasympathetic nerves and we want to build up the resistance and build up the strength of the sympathetic nerves so as to counter-balance the parasympathetic nerves. We must first take all of these things into consideration, the building up of resistance, overcoming infection in the intranasal passages and all air passages, and as brought out in the last paper, that cannot be done during the active stage.

Dr. F. C. Metzger, Sarasota (closing):

As has been brought out, it was absolutely impossible to go very deeply into this subject. I had to hit just the high spots.

Referring to Dr. Nichol's question as to the presence of other pollens on the west coast: Yes, there is a great deal of bermuda and natal grass here, and with the exception of two or three months out of the year, we find some grass pollen on our slides most of the time. I did not go into that in my paper, but the counts are available in my office, where you can get them any time you wish. In order to secure any real benefit from these counts they should be studied in detail.

As to the other question: When to do nasal surgery. That is quite a hard question to answer. It depends a great deal upon the kind of complications you have. In acute ethmoiditis, or any acute sinus involvement, I should say the time would then be right to do some palliative work to get rid of the acute stage. But, in general, I should say that after finding the sensitizing agent which is causing the most congestion in the nose. get that patient up to as high a point of desensitization as possible, and then do nasal surgery. That would probably be the best time.

I want to agree with one thing that Dr. Rivers brought out, as to the multiplicity of conditions or agents which can cause these reactions. It is no easy job to run them down and, as I have said, palliative measures are justifiable and necessary until (or if) this is accomplished.

I presented this paper this afternoon mainly with the idea of making the physicians of Florida allergy conscious.

I believe it is necessary for the doctors of our state to discourage the practice of sending asthma and hay fever victims to our climate, promising them relief; without a knowledge of their individual allergia, and a knowledge of the occurrence and distribution of these allergens in the various parts of Florida.

DIABETES IN THE HOME*

R. H. Knowlton, M.D.,
St. Petersburg.

Diabetes is a disease of metabolism caused by a shortage of active insulin. While the etiological factors concerned in this insulin failure are not yet fully understood, there are two rather divergent lines of thought, both of which are supported by clinical and experimental evidence. The "nervous" origin presumes an overproduction of some substance antagonistic to insulin, either by depressing its secretion[1] or inhibiting its action.[2]

A second idea long held is concerned with the overproduction of fat[3] as a cause of the disease, and certainly there is a definite relation between obesity and the incidence of diabetes. To the bystander it would seem possible that both these ideas could be utilized, the "nervous" origin to explain the disease in children and the fat origin to account for the milder forms of adult life.

Glycosuria is not synonomous with diabetes, in fact, two-thirds of the cases showing sugar in the urine are not diabetes at all. Reducing substances are normally found in all urines, sometimes in amounts detectable by the ordinary clinical tests. These small amounts represent the waste products of carbohydrate metabolism and constitute no sugar loss.

Renal glycosuria is a condition where sugar appears in the urine with a normal blood sugar. This is due to an increased permeability of the kidneys for glucose and is independent of diet. The glycosurias of pregnancy apparently belong to this group. The chief importance of this condition is to recognize that it is not diabetes, and while it may well be watched it should not be treated.

In alimentary glycosuria, on the other hand, sugar appears in the urine because the blood sugar is high following a carbohydrate meal. This is not due to a lack of insulin but rather to its slow action. Sugar is absorbed from the intestine faster than it can be taken up by the liver and tissues. Powelson and Wilder[4] believe that cases of alimentary hyperglycemia should be treated as diabetes until long observation has proved them innocent and also that the prognosis of glycosuria of pregnancy is not invariably favorable.

Hyperglycemia is not always due to diabetes. High blood sugar may be found in diseases of the thyroid and the pituitary glands, following chloroform and ether anesthesia, asphyxia, convulsions and other severe disturbances of metabolism.[5] Whenever doubt exists as to the cause of glycosuria the glucose tolerance test will determine whether it is due to diabetes or not. The fasting blood sugar level is determined and if less than 170,[6] one hundred grams of glucose are given by mouth. The blood sugar is tested again after two and three hours. The resultant curve shows a high rise, late maximum concentration and, most important, a protracted return to the fasting level. A simpler method used by Dr. John[7] is to take the blood sugar two and one-half hours after a rich carbohydrate meal, a high reading signifying diabetes.

A very few words about the carbohydrate metabolism.[6] The ingested carbohydrates are absorbed by the intestine mainly as glucose and carried to the liver by the blood stream. Here they are converted into glycogen and stored. Insulin may play an important part in this process. The rest of the glucose not stored in the liver and that derived from the liver glycogen goes by the blood stream to the tissues. The circulating glucose is abstracted from the blood and apparently by the action of insulin, is converted into tissue glycogen. This is reconverted into glucose as the need for it arises, a glucose changed in some way so that it is in a form which can now be used for combustion. The liver glucose cannot be so utilized but must first be converted into tissue glycogen. The function then of hepatic glycogen is to maintain the blood sugar level and that of tissue glycogen to supply glucose for combustion.

In the diabetic, due to the failure of insulin, the glucose is not readily absorbed from the blood and the blood sugar level rises. When it reaches a certain point, spoken of as the renal threshold, glucose overflows through the kidneys and is lost in the urine. The height of the renal threshold is not fixed but varies in different individuals and in the same individual under different circumstances.[6] Thus under certain conditions, as ether anesthesia or prolonged insulin therapy, it is possible to have a very high blood sugar without sugar in the urine.

Two classes of patients come to us, those where diabetes is discovered for the first time and more frequently the diabetic sinner who has backslid and returns meek and repentant. For both, there are two aids to offer, first the adjust-

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Assn., Sarasota, May 3, 4, 1932.

ment of the diet and second the addition of the thing they lack, namely insulin. When practical it is interesting to make a preliminary survey of the situation by having the patient collect a twenty-four-hour urine, and without change in the diet to keep an account of the amount of food consumed during this period. The approximate glucose tolerance can be estimated, and by comparison with the ensuing days his progress can be made evident to him.

It is no longer necessary to subject the patient to a very low diet. In the hospital a diet of around one hundred grams of carbohydrate, one hundred grams of fat and a gram of protein per kilo of body weight is low enough. If he does not become sugar free in a few days, insulin is gradually added until he does. In the home I prefer to take a few days to cut down the diet to this level, especially if the patient has been on a very liberal allowance before. If diacetic acid is present it is well to omit the added fat. There is no harm in hastening the process of desugarization by giving small amounts of insulin early in the treatment. One reason for not doing so is an entirely unwarranted belief on the part of the laity that once insulin is begun it must always be continued. This is entirely erroneous except in the case of children. Some physicians also have a somewhat exaggerated fear of insulin shock.[8] Five or ten units of insulin could be taken by any of us and the only result would be a somewhat increased impatience for dinner tonight. After all, the reduction of the patient's intake does not add anything to him. Small amounts of insulin not only help reduce the excess sugar in his blood but add it to his glycogen reserve and give him that much defense against acidosis.

Most authors agree that a preliminary stay in a hospital is very advantageous. However, if a diabetic clinic is not available, it is possible to carry out the treatment in the home unless the case is very severe or complicated. After all the diabetic is going to live in the home and the main object of the hospital is to teach him how to care for himself there.

Certain supplies are necessary to start his education: first of all, food scales which weigh in grams, for the English system is too cumbersome to use in diabetes; a ledger for writing down the amounts of food taken and the grams of protein, fat and carbohydrate in separate columns; a diabetic manual which contains a table of food analyses; a laboratory outfit of test tubes, Benedict's solution, and a bottle of Ferric chloride solution to test for diacetic acid.

The computation of food values seems a very formidable problem at first but there are certain aids which make it rather simple. If the food portions are kept in round numbers, the computation becomes merely a matter of inspection. Thus 100 grams of orange juice yield 10 grams of carbohydrate and 100 grams of meat, 20 grams of protein, and the same of fat, and so on. It is safer to avoid fractions in the summary and to put down the nearest whole number; the result will be almost identically the same and confusion is avoided. A diabetic nurse or a patient who has been previously trained, may be used to teach, when available. However, it is very surprising to see the ease with which the average patient masters the principles of food values in a very short time. By planning his own diet, instead of using set formulas, he is able to eat what the rest of the family do and to vary his daily menus.

Special foods for the diabetic are largely a delusion, particularly the bread substitutes. In the past the patient could well exclaim, "What man of you when if his son asks bread, will he give him a stone?" Perhaps he would have done so yesterday, but not today. As Dr. Foster says,[9] "Far better for him physically, and transcendently better for him mentally and morally to eat real honest bread, figure the cost in starch and pay for it in units of insulin." There is no material difference between whole wheat bread and white bread as far as starch is concerned. This seems a small point yet I have known a patient who was most careful to avoid white bread while taking enormous amounts of whole wheat bread with the idea it contained no carbohydrate.

The physician should not administer the insulin except perhaps for the first few doses, but the patient should be taught to do it himself. If he cannot, then some other member of the family who will always be at hand should give it. To avoid confusion it is well to use only one strength of insulin. U 20 is best, and it should always be measured as units, not in minims. The syringe purchased by the patient should be inspected and its measurements explained, for the markings are sometimes very confusing.

The patient should be cautioned that as time goes on, his tolerance will probably improve, and

that when slight degrees of insulin reaction appear the dose should be reduced. The amount taken depends upon the individual, and after the urine has become sugar free a morning and evening dose are sufficient. During the early part of the treatment it is well to test the urine before each dose and to modify the amount of insulin accordingly. When sugar free the diet should be gradually raised to a point which will supply energy requirements but not enough to produce overweight. While there is no need of the severe under-nutrition diets which, before insulin, were the mainstay of treatment, insulin should not be abused to satisfy a gluttonous appetite. Just how many calories will be needed is a matter of individual experimentation. There is no set of rules or mathematical tables which will apply to all persons. Some people eat well and remain thin and others take little and wax fat.

The average adult's requirement of protein is said to be about one gram for each kilo of body weight; children need at least twice that much.[9] Formerly the carbohydrates were placed low and the rest of the calories supplied by fat. Nowadays the tendency is the other way, the fat fixed at 100 grams or a little more and the remainder of the calories supplied by carbohydrate with sufficient insulin to balance it. Even after the advent of insulin the profession has been grudging in allowing carbohydrate, but the allowance has been increasing through the years. Joslin estimates the present allowance as between 100 and 200 grams with an average of 150.[10] It is probably safer for most of us to avoid the extremely high carbohydrate diets which nevertheless seem to give good results in the hands of their advocates.

High fat diets are no longer in vogue. Fat may provide an ideal food for the Esquimo but it is an unnatural diet for our people. Besides this, there is always the danger of incomplete combustion and resultant acidosis. Many of us must have observed that some patients who are on a balanced diet will show sugar again when a small increase of fat is made. Finally there is a growing feeling that the high fat diets formerly used may be a cause of the arterial degeneration which is now supplanting coma as a cause of death.

There are some other warnings that should be given the patient. Moderate exercise is beneficial to the mild diabetic and may take the place of a dose of insulin. In the severe cases more caution must be used for prolonged overexertion may precipitate coma. Joslin[10] teaches that the diabetic should be the cleanest one in the community, giving especial attention to the feet. He should know that infection of any sort exerts an antagonistic effect on insulin action. Even with a cold, he should test the urine frequently and take repeated small doses of insulin to keep the urine practically sugar free. In fact the sudden lowering of glucose tolerance may sometimes indicate the presence of unsuspected pus. Such a case once came under my observation where mastoid disease was diagnosed by the sudden increase of urinary sugar, where all other signs were absent, save the X-ray evidence.

The diabetic should be encouraged to believe that his disease is benign and that he can live out his allotted span, provided he makes the necessary concessions. But he should be warned that if he persists in ignoring his condition, retribution will surely overtake him, if not in the form of coma then in the hopeless degeneration of arteries of the retina, heart or extremities.

Finally he must be warned against being led astray by the claims of charlatans which too often are found in the advertising columns of our newspapers. That when something better than diet and insulin is found his doctor will know about it, and that he owes his present happy state to these leaders of the medical profession who have devoted their lives to the study of his disease.

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DISCUSSION

Dr. W. C. Blake, Tampa:

I have enjoyed Dr. Knowlton's paper very much. He has outlined very nicely the really

simple requirements necessary for controlling diabetes. Often it is looked upon as a very formidable condition, one requiring a great deal of technical information, when as a matter of fact the requirements usually are very simple. I believe it can be stated without any question of doubt, that diabetes is probably the most poorly treated common disease with which the practitioner of medicine comes in contact. Just why this should be I can't quite understand. There seems to linger much of the hopelessness surrounding it in pre-insulin days. As a matter of fact there is no disease where a more spectacular response to treatment can be obtained. In the absence of severe complications, the indications for its management are clear-cut and definite.

With regard to alimentary glycosuria, I realize that it is really a fairly common condition. It is, of course, the usual response to excessive ingestion of carbohydrate food. It is to be remembered, however, that oft repeated alimentary glycosuria leads inevitably to diabetes mellitus. The burden of proof, therefore, is up to the physician, in the presence of any glycosuria. Frequently a true evaluation of the situation can be made only on the basis of a glucose tolerance test.

The most important thing in the treatment of diabetes is the education of the patient. No patient has been properly treated who has not been taught to calculate and weigh his diets and test his urine for sugar and acetone. As Dr. Knowlton has pointed out, this is not a formidable undertaking. Most patients learn in a surprisingly short time. When you consider that the diabetic has a condition that will continue to exist in mild or severe form for the balance of his life, it becomes apparent how vitally important education is. Give him a simple diabetic manual, encourage him to read it, question him on it frequently and you will be surprised how much information he has acquired in a really short period of time. If he understands what he is doing and why he is doing it he is much more apt to carry out instructions than when he is following blindly. Only in this way can he minimize the natural progressiveness of the disease and avoid the pitfalls that lurk with every mild intercurrent infection.

It is a mistake to feel that diabetes is primarily a disease requiring hospitalization. The hospital, of course, with its trained nursing staff and readily accessible chemical laboratory make convenient the training of the patient and the preliminary adjustment of diet and insulin. With ambulant cases I frequently allow them to stay at home under the care of a trained diabetic nurse for a few days to a week during which time they can come to the office as often as necessary for blood sugar estimations and such other laboratory procedure as is indicated.

It is surprising how closely balanced the well-trained diabetic can keep himself for long periods of time. It is also hard to estimate his educational value to the community.

Dr. N. M. Marr, St. Petersburg:

I hope that you will pardon me for repeating some of the statements of Drs. Knowlton and Blake, already made to you, as to the education of the diabetic. Too much cannot be said along that line. It is of paramount importance in the management of a diabetic to have the individual educated to take care of himself. The vast majority of them, as Dr. Blake stated, grasp it in a short length of time. In Florida I feel that we have a class of people that can be, with few exceptions, taught percentage and how to compute their diet in terms of grams.

One other point has not been brought out. That is the test diet. Before insulin the test diet was a necessary thing. Since the advent of insulin, I do not believe the test diet has any place whatever in the management of diabetes. The test diet in my estimation is inadequate. If an individual cannot tolerate 100 grams of carbohydrates without showing glycosuria I believe that is a case for insulin. It is really pitiful to see the number of diabetics around the country who go through life for years not knowing they can eat potatoes or not knowing that they can eat bread. The first thing to tell a diabetic is that there is nothing he cannot eat in a certain amount, which must be determined when the diet is laid down.

The question of the amount of insulin depends upon the individual. That is a problem that the doctor has to solve for each patient. It is an individual problem with several factors to be considered. Let me repeat, that the diabetic who cannot tolerate more than 100 grams of carbohydrates a day, should be an insulin case.

Dr. Louie Limbaugh, Jacksonville:

I have enjoyed Dr. Knowlton's paper very much.

I would like to discuss one phase of insulin for

just a moment—the fear of insulin. I feel that doctors are responsible for a great many serious complications and accidents in diabetic patients. I saw a typical case just last week, a known diabetic of several years' duration who had developed an extensive carbuncle across the forehead. The family physician was called, and gave her as he stated "three full drops of insulin twice that day," and she gradually got worse. I said, "Well, Doctor, why not larger doses?" He was "afraid of insulin shock and reaction."

The life of a diabetic who develops any complication is certainly in the hands of that patient's family physician. The family doctor will be called first. Whether in the city or the country does not matter, the patient will call the family doctor. If complication is there, infection especially, and sugar is found in the urine, insulin is indicated and indicated at once. The doctor can easily check the urinalysis and if sugar is present give insulin and give a sufficient amount—to be conservative, 10 units at least. As a matter of fact one can give 20 units just as safely. Recheck the urine in two hours for sugar, catheterize if necessary. Watch the urine every two or three hours, and give sufficient insulin. There is very little danger of insulin shock, and if you do get a shock it is most easily handled. The patient will not die suddenly. After you are called, a tablespoonful of Karo syrup or cane syrup will bring him out of it in a few minutes. If he should lapse into an unconscious or semiconscious state, a c.c. of adrenalin will bring him out of the insulin shock for a few moments with sufficient time to give Karo syrup, cane syrup, or even ordinary sugar. It is safe to give insulin, and the patient who does not receive sufficient insulin and does have a serious infection or even a slight infection will certainly become quite ill and probably will die unless treatment is instituted thoroughly and promptly; and the first man who will see that patient will be the family doctor. Certainly the directions on an insulin vial are sufficient to acquaint him with the dosage as expressed in units or cubic centimeters—not drops. The doctor, in my experience, is afraid of the insulin, so naturally the family is.

There is a widespread belief, as has been brought out by our essayist, that once on insulin, always on insulin. That is not true, as he says. I feel that if a patient comes to us with sugar, and a theoretical maintenance diet, not a test diet, figured out for him, and the patient put on that diet and given sufficient insulin to get sugar-free, then we may gradually cut down on insulin if his tolerance is over 100 grams and he can be kept sugar-free. You may possibly eliminate his insulin. If it is found to be unnecessary, discontinue it. It is very good for the patient to have been on insulin for a few days, or a week if necessary, whether in the hospital or not. He will have more satisfactory treatment in the hospital, but there are exceptions when we have to treat these cases. I think to give them insulin is a good thing. They are no longer afraid of it, and they know that they can get off of it, rather than to lose perhaps a few days to see whether or not they can tolerate 100 grams of carbohydrate daily. Why not give them a maintenance diet and gradually build up the dose of insulin until they get sugar-free, and then check the blood sugar and urine, and gradually reduce the dose of insulin if possible.

Dr. R. H. Knowlton, St. Petersburg (closing):

I wish to thank my friends who treated this paper so kindly in their remarks. The discussion is probably the best part of the paper.

The point that I tried to bring out was that the patient should be educated. Dr. McKenzie used to educate his patients as to the use of digitalis in heart disease, and I think the same should be done in diabetes. The patient must understand diets and he must understand the indications for more insulin or less insulin. The doctor, if he is going to treat the patient and tell him how to select food, must first know food values himself.

Another point that I might have stated is that the patient does not have to use scales all of his life. He soon gets to where he can estimate the weight of an orange, etc., almost exactly, and after a few weeks he can dispense with his scales. A very important point is that the patient must be taught that he must not get too fat.

THE GOLDEN DECADE OF MEDICINE, AND THE GROUPING OF EVENTS BY DECADES*

L. S. Oppenheimer, M.D.,
Tampa.

By the term, "Golden Decade of Medicine", is meant the seventies of the last century. Most of the greatest discoveries of two centuries were

*Read before the Thirteenth Annual Meeting of the Florida Railway Surgeons' Assn., Sarasota, May 2, 1932.

crowded into this same narrow hiatus of time.

We have become so accustomed to believe in the "grouping of events" without attempting to explain the phenomena that cause them, that we fail to realize there really may be physical or psychical causes that bring about correlated conditions, either relatively, simultaneously, or in chronological proximate sequence.

A careful analytical investigation will often solve the causes, clear up their seeming strangeness or mysteriousness, and reduce them to fundamental laws of cause and effect, and not to mere chance.

We will find contemporaneous grouping of men of genius, or of individuals working independently in inter-related fields, or peculiar workings of some psychical, physical, natural laws. For instance, the foundation of American literature was laid by six men, three living in Concord, Mass., and three at Cambridge 15 miles away. Greece had a group of seven thinkers during the time of Pericles, who made the name and fame of Athens deathless; Pythagoras, Plato, Socrates, Aristotle and Xenophen. The three greatest artists who ever lived, Leonardo da Vinci, Michael Angelo and Rafael, lived and worked in the same period. In the first two decades of the last century the star of the Muses dominated a constellation of poets that has never been equalled in brilliancy or number in history. Byron, Scott, Burns, Moore, Keats, Shelley, Wordsworth, Heine, Longfellow, Poe, Whittier, Bryant, Tennyson, are these immortals.

The decade of the '70s in the last century, including the few years before and after, deserves to be designated "The Golden Age of Medicine," because it was then that modern medicine, surgery, and science received their vital impetus and recorded the first great pages of their history.

The philosopher wrote:

"Yesterday is history;
Tomorrow is mystery;
Today is the golden hour between,"

the hour in which to build the foundation of experience and wisdom.

It is interesting to recall that in that yesterday, there prevailed such mysterious things as perityphlitis, cecal abscess, laudable pus, setons, wet and dry cupping, leeches, blisters, poultices, miasms, idiopathic diseases, vaccination with infected scabs taken from vaccinated people, puking, purging and bleeding, and a host of other forgotten theories and popular infallible occult things.

Around that period it was a fad among professional men to affect the dignity of ornate, hirsute facial adornments. Beards, Vandykes, whiskers, goatees and pretty mustaches were badges of the high-brows. Your humble servant at the mature age of 24 proudly paraded a beautiful beard parted in the middle, wore a high-top hat, and a Prince Albert coat, like Father Grimes', "All buttoned down before," insignia of the intelligentsia. Manicured nails were as rare as toothbrushes, and unmanicured ones presented no terrors to the average surgeon.

As we enter this decade, the name of the immortal Pasteur is carved over the portals as he opens them wide for future humanity. He is in the midst of his investigations in fermentation, putrifaction, bacteria, immunizing serums, etc. The chemist and physicist leads the surgeon and physician into a new world.

Lister sees the causes of past failures and at once puts the new knowledge of infection and antisepsis into practical use. Success was immediate and convincing. He performed nearly all surgical work under a carbolic spray, and opened the new era in surgery.

In 1877 one of Lord Lister's assistants invited me to assist him in a laparotomy at St. Bartholomew's Hospital in London. A spray of carbolic solution was kept playing over the wound and our hands, so diluted, however, that it did not materially benumb the hands. It is significant that few of Lister's assistants made any phenomenal stir in the surgical world.

The most skillful and daring surgeon of this period was universally conceded to be Prof. Theodor Billroth of Vienna. He operated with ten or twelve assistants, young doctors, nearly all of whom wore beards, including Billroth himself. No trained nurses were in evidence in those days. We, Lords of Creation, had not yet permitted women to evolute from child-bearing, child-rearing and housekeeping.

"Billroth's Surgical Pathology" was a pioneer in this class.

Ether anesthesia was first discovered by Dr. Crawford S. Long in the little town of Jefferson, Ga., in 1842, but Dr. Morton, a Boston dentist, four years later, first demonstrated it to the world at the Massachusetts General Hospital. However, chloroform continued to be the uni-

versal favorite until the very end of this decade.

Heinrich Hertz discovered the controllable propagation of electricity through space without a visible medium of communication, formulated laws governing the same, measured the wave lengths, the velocity, etc., and gave to the world the introduction of the radio.

Sir Joseph J. Thomson discovered the electron, destined to change the very fundamental problems of the universe.

The vacuum tube of Crookes, invented a few years before, enabled Edison in this decade to transform night into day; a few years later gave Roentgen the medium to reveal the X-ray; to Marconi and DeForrest the secret of perfecting the audion or radio-vacuum tube which annihilated space and distance.

And Bell, who originated the telephone in that time, quickly inspired Edison to produce the recording of sound, the phonograph, and the moving picture. A lone philosopher or scientist rarely arouses the world. It takes bulk to make a conflagration.

You have noticed that very commonly your patients improve or retrograde in "bunches"; that most sick people are worse at night. Nearly always the cause lies in the changes in barometric pressure or other meteorological influences.

Semmelweis and Oliver W. Holmes had tried for years in vain to convince the world that childbed fever was due to infection carried into the vagina by pragmatic midwifery. Semmelweis and his theories were treated with contempt and ridicule.

Even in the Allgemeines Krankenhaus of Vienna, where he had once been an assistant, and in whose same obstetrical wards I spent many a night as a working student, twenty years after, the same antiquated methods of ward and bed disinfection prevailed.

Hand washing in most countries was done in a more or less perfunctory manner, with solutions of mercury bichloride, chloride of lime, potassium permanganate, followed by weak oxalic acid, etc.

Although McDowell of Kentucky had years before demonstrated the practicability of the Cesarian operation under most adverse environments, it was not until the Listerian decade that the surgical conscience and faith awakened to its safety and feasibility.

The fields of biology and embryology were just opening. The only laboratory in the world was in the Gewehrfabrik of the University of Vienna. The writer had the rare privilege in 1876-77 to serve as ex-officio assistant to Prof. Louis Schenck in this laboratory.

J. Marion Sims was named in this period, the Father of Gynecology. His genius opened a new field in gynecological operations. His skill aroused the admiration of the whole civilized world, and was sought by many of the best surgeons of Europe and America. He was decorated by the Kings of Italy, Spain, Belgium, Queen Victoria, the Legion of Honor of France, and others. He was the founder of the first woman's hospital in New York. His bronze statue in Bryant Park, New York, was the first full-size statue ever erected to a physician.

Lewis Sayre was the outstanding authority of the century on orthopedic surgery. During this decade he instituted many progressive, original ideas and orthopedic appliances; was the first to use plaster of Paris jackets; was co-founder of the N. Y. Academy of Medicine, Belleview Hospital, and the American Medical Association.

No group of men have done more to bring American surgery and medicine into the foreground than the famous quaternary of Johns Hopkins, Welch, Halstead, Kelly and Osler, whose life-size group-painting by Sargent adorns the main hall of Gillman Hall of Johns Hopkins University. Halstead introduced rubber gloves; Welch made valuable original contributions to bacteriology and pathology; Kelly of phenomenal memory, popularized gynecology and abdominal surgery, is still actively contributing to surgical literature, and evoked from Osler the well-known statement, "The most skillful laparotomist I ever saw"; Osler, the universally recognized prince of practical diagnosticians, the paragon of teachers, the ideal physician.

Other makers of medical history in this epoch abound. I will briefly mention a few: Rudolf Virchow formulated the axiom, *Omnia cellula e cellula*—every cell comes from a cell—and threw the light of science and biology on the entire realm of plant and animal life; Henle, the germ theory of disease; Claude Bernard, father of endocrinology; Laverans, the malarial parasite; Eberth, the typhoid bacillus; Koch, the tubercular bacillus; Neisser, the gonococcus; Klebs, the diphtheria bacillus; Fraenkel, the pneumonia diplococcus.

In our own time, within the past decade, five men of transcendent genius have acted upon the world's moving stage, whose names should go down in history on the same page with Newton. They are: Einstein, Edison, Steinmetz, Millikan and Michelsen; each of whom personally and intimately knew the others.

In this same entrance into this century already have been crowded the automobile, submarine, flying machine, moving picture, radio, audion or radio-vacuum tube, sound projection by means of the photo-electrical cell; automatic telephone, and other remarkable discoveries. At this very moment are in process of making new discoveries which further emphasize this "grouping of events."

"In a world in which the marvelous has become the commonplace, the well-nigh miraculous, the expected, a world which has been made *blasé* by the mere plethora of amazing scientific developments," the word *impossible* has been deprived of its former significance.

TRANSURETHRAL PROSTATOTOMY FOR RELIEF OF VESICAL ORIFICE OBSTRUCTION WITH THE McCARTHY LOOP OR RESECTOTOME*

GIDEON TIMBERLAKE, M.D., F.A.C.S.,
St. Petersburg.

The subject of urology has taken many whirls and great progress has been made, mostly for the better, looking to diagnosis and relief of conditions which, hitherto, have been fraught with a fairly high mortality rate and many misgivings because of lack of assurance. I find no occasion here to enumerate many of them for the reason that they are now so obvious to all who are interested.

Enlargement of the prostate gland and its removal seem as much on the minds of the aging and aged, and its vagaries as horrible as those experienced by women who either are approaching or are well into their climacteric—just a mass of confusion, discomfort and unhappiness.

For many years it has been known that the prostate gland, with its various pathological changes, has been the greatest hazard of old men. These conditions have been studied from a vast number of angles and, to date, there has been no adequate solution, with exception of inflammatory processes, for any of them. At all events, the most highly important item in the whole scheme is proper recognition of the offender and its removal by the simplest possible methods. Further, there is hardly one of these prostatics who does not have, way back in his mind, that all-absorbing thought: "What effect will the operation have upon my sexual powers?" Not only do the men have it, and while they do not express themselves so boldly, their legal or other consorts ask the very same question in another fashion: "Doctor, do you think he will be all right when this is over?" This is one of life's schemes difficult to efface and impossible to prohibit by legislation!

It is conceded that about 80% of all men who are sexually competent incident to prostatectomy by either the suprapubic or infrapubic routes resume their sexual function. This seems to obtain regardless of whether the verumontanum is wrecked by either route. Young stresses the point that, by his method of perineal prostatectomy, the veru is conserved on the "ejaculatory bridge." I concede that, in certain instances, it is. Regardless of all this, the mortality in prostatectomies has, through careful studies of renal function, blood chemistry and proper drainage been reduced to about 4%. This must, of necessity, be regarded as excellent. One of the gruesome hazards consequent upon either approach and attack, along with other complications, is that of epididymitis, which in most instances becomes suppurative. This, now, is greatly alleviated by vasectomy or vas ligation incident to operation. At that, many of them are delayed by developing epididymitis which result from too ardent, filthy and frequent instru-

*Read before the Pinellas County Medical Society, St. Petersburg, April 7, 1932.

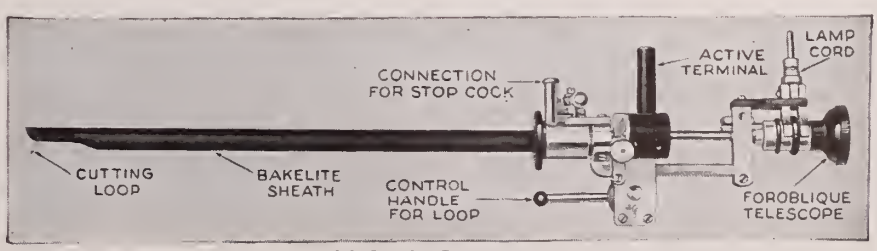
mentations for relief of urinary obstructions or investigations for diagnosis.

Conceding the wonderful work done toward perfecting radical prostatectomies and insuring lower mortality rates, we must come to a point and pause to consider what relief of urinary obstruction actually means to the patient when he has not to be subjected to the channels of radicalism; what misery he is spared; what expense he is saved. Of almost equal importance is the conservation of his sexual function. Regardless of any recommendations to the contrary, they all cling to this thought, if nothing else!

Since the days of Mercier, some time later to be followed by Bottini, we have cruised through an era of constructive improvement. Young conceived and devised the prostatic punch and, while very efficient for small obstructive areas, its field of activity is limited. Until he devised a means of arrest of hemorrhage by application of direct heat to incised parts, hemorrhage in most instances was pronounced. From this, we must give Caulk credit for having devised his cautery punch, in whose hands it has served splendidly. The Collins' electrotome not only had but has its place as a very efficient instrument. The Stern loop or resectoscope has been used extensively and more generously exploited by Davis, whom I have seen working with it. This instrument has considerable merit.

Bumpus has carried on, and most intelligently, with his pronged electro-coagulating devise with which he actually cooks the parts to be resected through his punch. I advised this measure many years ago, i. e., coagulating before punching.

The latest gadget on the horizon seems to be that of Doctor Joseph McCarthy of New York, though I have not surveyed the current news for almost a week! I am strongly of the impression that this instrument will go further to solve the problem of removal of vesical neck obstructions than all others and, as I view it, will prove to be better than the Stern-Davis instrument. Rather than an all metal affair, the McCarthy instrument has a boilable, non-conducting bakelite sheath which is straight and may be introduced with his straight obturator through which runs a boule-tipped flexible searcher. To this, I added a straight metal obturator with a movable coudé or elbow tip about one inch in length that breaks forward from a hinge casually or may be drawn back by a proximal thumb-button and has a sweep of about 45 degrees forward to afford a curved instrument to traverse a curved field. However, this does not preclude the use of the inflexible obturator. With the foroblique McCarthy telescope one may see almost directly ahead and, as resection is done, his vision is brought more nearly on a plane with his line of activities and resections and when he can look directly at the ureteral orifices and interureteric ligament he is more reasonably assured that the object of his attack has been removed. Another point of great importance demonstrated in using the bakelite sheath is that, when the current-carrying loop is drawn by the rack into the sheath, the current is broken. This tends, at least, to make it more nearly fool proof! Through this instrument one can introduce a small hemostatic bag to be filled and drawn taut against and within the vesical orifice to later be decompressed and withdrawn through urethra. Almost all hemorrhage can be stopped before concluding, and this done, application of loop with current to bleeding area or by using the Timberlake adjustable electrode through a catheterizing cystoscope. The lateral



McCarthy Instrument
(Courtesy of American Cystoscope Makers, Inc., New York)

prostatic arteries that arise from the inferior vesical arteries are the chief offenders and can be seen to spurt.

From what I can gather, all those using either the Stern or McCarthy instruments withdraw their loops after each cut and salvage the particle of tissue. I neither employ that method nor can I see use for it. Much time is saved by repeating the cuts as often as possible, permitting them to drop back into bladder for them to be later evacuated. Many of the particles come out when the operating instrument is withdrawn while the bladder is given a good lavage for clarity of vision in order to resume work. While I keep a more or less constant stream of cold solution going down the tube during resections, there are times when the bladder is of great capacity that this is not needed.

I do not retrieve each section following each cut. Continue sections until the particles obstruct vision and procedure, then evacuate them through sheath and resume work. Through this all manner of tissue can be removed. Should there be any mass of unreturned particles, immediate employment of the Young's cystoscopic rongeur seems sufficient. In some cases, I have depended upon the patients to evacuate them by the natural expulsory processes and to my delight have found, after a few days, that the bladder was free of them. It is my intention, in this connection, to have made an evacuating tube of similar dimensions and curve, but with a longer and deeper fenestrum to be plugged by a knobbed obturator fixed on a flexible ribbon of steel. This will make access to bladder very simple and the very least traumatic. To this may be attached an evacuating bulb whereby many particles may be sucked out.

The diagnosis and determination of cases to be subjected to this process must, naturally, be dependent upon clinical history, rectal examination, cystoscopic examinations and cystograms. If calculi be present one does not have to be deterred in the resections. They may be accomplished to be later followed by lithilopaxy, which cannot be satisfactorily done when there is a high dam of prostate. These cases are done under caudal or spinal anesthesia and I have been informed by those operated upon that they have suffered little if any pain—and they should know! One exception stands out, but this was all due to some confusion in the machine and more to be blamed on me than anything else. Residual urine has been reduced in one case from 500 c.c., and in another from 180 c.c. to none or a negligible quantity. I employ a larger retention catheter following these than others and leave it in for a much shorter time, the reason being that, any foreign body—however clean—if left in for any great period sets up an urethritis.

It must be clear that any device for relief of ardent obstructive symptoms to urinary flow, more or less constant pain, mental anguishes caused by apprehension, loss of sleep, bleeding and reasonable assurance that some remaining vestige of libido may be conserved along with reestablishment of urinary function, to say nothing of being able to avoid the horrors of hospitals over long periods and radical measures, must recommend it.

To say that this is not a highly technical measure would be fatuous. I regard it as almost dangerous unless one is qualified as an instrumenteur and enjoys a knowledge of endovesical procedure that has come from hard experience.

CONCLUSIONS

1. Prostatotomies, extensive or meagre, must not be regarded as supplanting frank surgical prostatectomies. That this method will reduce necessity for radical prostatectomies, there can be little doubt. Hospitalization about four or five days.

2. Complete carcinomatous involvement of the prostate preclude these measures. The prostatic urethra, in carcinoma, is invariably structurized or contracted throughout.

3. I have failed in a few instances, which is more than one operator seems to have admitted, but each mistake—and none have hurt patients appreciably—has been salvaged for constructive profit.

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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SO-CALLED CHARITY

Any one who has noted the great changes which have taken place in medical practice during the past twenty years and the attitude of some of the lay groups toward the physician's time and remuneration cannot but see looming ahead of us "State Medicine." We may not like the term nor what it stands for. Nevertheless, it is in front of us and we will have to surmount or circumvert it, as best we may, become state employees or select a different profession.

Everywhere, not alone in Florida, there are springing up clinics of all kinds, fostered by clubs, some of the members of which feel they must have some type of welfare work in order to justify the club's existence, and always the physician is called upon and sometimes almost coerced into giving his services to make the activity a success. That would not be so bad were it not for the fact that these clinics are being advertised as free—just like salvation. These sponsors seem to forget or ignore the fact that the time of the physician is part of his stock in trade, as well as the knowledge and skill which he spent so many years in acquiring. The sponsor's cry is that these people need, but cannot get proper and skillful medical attention. They lose sight of the fact that the physician is the greatest contributor to charity in his community and will continue to be, for it is one of our greatest traditions that the poor and indigent shall always be cared for, quite unselfishly. However, this charitable attitude on his part should not be imposed upon and he should not be asked to man a clinic to which anyone may come, whether indigent or not.

A further step toward this jugernaut, State Medicine, is expressed in some States in the attitude taken by political groups, who hold that the provision of sick care for the poor is an obligation of the State, somewhat like the Veterans' Bureau ideas (that hospitalization should be provided for all veterans, even with a non-service disability.) This would place a burden or tax for hospitals and medical care upon the thrifty, conscientious hardworking citizens; apparently a penalty for being progressive and painstaking, and an encouragement of carelessness and indifference to health.

Note the plight of the physicians in New York City, who receive appointments on hospital staffs, from the Department of Hospitals. They must serve without compensation and are distinctly prohibited from collecting fees for care of patients, who are covered under the Workmen's Compensation Act. Yet, these institutions collect monies for care of the said cases. Also each hospital has a free clinic, which must be manned by the hospital staff and to which come alike the well-to-do and the poor. The laws moulded by the attorneys, provide for compensation for the lawyer who is appointed by the Court to serve the indigent criminal: yet, the same individual, when he comes to the hospital, is tended by the physician without charge. The taxpayer's money is spent to pay a lawyer to contest execution of or by the law, yet not a penny is provided for the physician who defends that life against death from disease or injury. Is this justice?

And now, following the lead of the city politician, the committee appointed by Governor Roosevelt to review medical and hospital problems recommends the establishment of state clinics conducted as are those in the city. The argument is that this will provide cheap medical care. The one thing that the really sick ones demand is not cheap, but better, medical care and that comes through the employment of a free physician, one whose success and progress in his profession depends upon his reputation for fair dealings and knowledge of his subject and not upon the political pull he can exact. Socialized, standardized, paternal care of the sick will result in a horde of political job holders, including welfare workers, public health nurses, administrative clerks and will result in cheap professional care with increased taxation, and is no more to be desired than state religion.

One step toward preventing, or at least delaying, such a state of affairs in Florida would be for the physician to refuse to act on any clinic staff save one developed and operated by the physicians themselves and which would be open only to those who are truly indigent. By concerted action of city and county physicians with the already functioning welfare groups and the Salvation Army, this type of clinic could be maintained, serve all the truly needy, and relieve the physicians from charges of self-interest, indifference to the needy suffering and antagonism to self-styled welfare workers.

FIRST AID FOR MAD DOG BITES

During the past twelve months there have been five deaths from hydrophobia in the State. Three of the victims had completed treatment but developed symptoms before the treatment had had the necessary time for the production of immunity. The antirabic treatment as developed by Pasteur requires 14 to 21 days after completion of the prescribed number of inoculations before the patient can be assured protection.

As an added safeguard, one which in some

circumstances is very important, it is recommended that the wound be treated by the direct instillation of fuming nitric acid. Owing to the nature of the acid a finely drawn out glass pipette or glass rod is required for the introduction of the acid the full depth of the wound. The virus travels very slowly in the tissues or along the nerve trunks, therefore fuming nitric acid instilled early has a fair opportunity to destroy the rabies virus. Other disinfectants like formaldehyde, mercurochrome, iodine, etc., are of no value for treating wounds caused by the bite of a rabid dog.

The treatment is severe and ugly sloughs may follow but even so the consequences are preferable to having rabies or hydrophobia.

CORRESPONDENCE

The Journal is pleased that members of the Association are taking advantage of this column to express their individual views.

The ideas of our members and comments on letters published are solicited.

VETERANS' RELIEF

To the Editor: One of the most vexing questions confronting Congress today is a proper type of veterans' relief. Apostles of various types are parading their views and it seems as if each congressman looks at the question from a slightly different angle. The present Veterans' Bureau has a most ambitious program calling for the erection of hospitals with a total capacity of 150,000 beds in order to take care of all veterans whether suffering from service connected disabilities or not. We feel that any veteran with a distinct service contracted disability is entitled to every consideration, but we also feel that for a non-service disability he is no more entitled to hospitalization at the public expense than is any citizen or especially any taxpayer.

This question is one which is of great interest to all physicians, for by constructing government hospitals to house these veterans, an economic loss will result. Many of our present hospitals are barely making ends meet financially and with the competition of hospitals free to veterans and their families, it will be necessary to close their doors. This will injure many of us who are connected with hospitals to which we have given the best years of our lives in order to place them and keep them on a paying basis.

As a solution for the abuses in veterans' relief which now are costing the taxpayer nearly a billion dollars yearly, The Cleveland Press, in an article by Talcott Powell, presents an apparently sound program, at least one which has many features to commend it, as follows:

A—Raise the compensation payments of men clearly injured in service to a permanent degree, *providing* they need the money.

B—Raise the payments to widows, children and dependent parents of men who really did die for their country in the World War.

C—Remedy apparent abuses in the emergency officers' pension law.

D—Compensate *only for service-connected* disabilities.

E—Hospitalize *only for service-connected* disabilities.

F—Eliminate absurd congressional presumptions of what did or did not happen in the World War or when it ended or what a man's physical condition was when he entered the service. Depend instead upon competent medical opinion.

G—Place war risk insurance upon the same business basis that obtains in a private company, with the exception that the government shall make no profit out of its soldier insurance.

H—Treat the veterans of all wars alike.

I—Make the *economic situation* of the veterans a controlling factor in any benefit he receives from the taxpayer.

J—Create a permanent standing Congressional Veterans' Relief Committee whose members will specialize in veterans' legislation. No such committee now exists. Such a committee would not only result in more intelligent veterans' legislation, but would make it possible for the public to fix responsibility.

A program like this might well receive careful consideration by the physicians, for if the present Veterans' Bureau Hospital plan goes through, quite a large percentage of our practice will be legislated into government hospitals and into the hands of contract surgeons.

(Signed) G. H. Edwards, M.D.

INCREASING DANGER OF MALARIA

To the Editor: Three years ago Florida experienced the highest incidence of malaria since the year 1919. The lessened rainfall during the year caused many temporary water holes to dry up.

The number of cases of malaria appear to have diminished to about one-third of what it was in 1929. With the recent heavy rains there has been a very wide increase in mosquito production in Florida and the Anophelene group in particular. *Anopheles crucians* has been found in an abundance heretofore unknown in Duval County. The same conditions will prevail elsewhere under similar conditions of drought and subsequent heavy rains.

It is suggested the family doctor warn his families of the increasing danger of malaria and that the most practical immediate protection is a well screened mosquito proof house.

People should avoid, as much as possible, being out on unscreened porches from dusk to 10:00 p.m. or at dawn.

The so-called "rock gardens" in which gold fish are raised will produce Anopheles unless kept clean. If the fish are overfed they will not consume many mosquito larvae.

Some of the large cities in the State are producing enough Anopheles from such pools to infect a large portion of the city population with malaria.

(Signed) HENRY HANSON, M.D.,
State Health Officer.

THE EIGHTEENTH AMENDMENT

To the Editor: Whenever the question arises among medical men in Florida on the stand to be taken in regard to the Eighteenth Amendment and the Enabling Volstead Act, someone always advances the smug thought that it does not interest us professionally, as we in Florida have been unable to prescribe alcohol and its therapeutic derivities for nearly thirty years.

That stand is distinctly narrow, a sort of "Am I my brother's keeper" attitude. We, who feel that way, are prone to forget that our confreres in nearly all the other states have had placed—it was unsought—upon their shoulders the responsibility of the proper dispensing of this therapeutic agent.

We believe that no physician desires to shirk a responsibility which our government places upon him, but most of us feel that we, who are trained to analyze a diseased condition and to give the proper medication for relief, should not be hampered and handicapped by the very irksome and irrational restrictions, propounded by laymen, which were handed to us at the same time we were made supervisors: viz: (a) a limitation to the number of prescriptions a physician may write in three months; (b) the recording on said prescription the condition from which our patient is suffering.

If the State gives us the right, after suitable tests, to supervise the health of the citizenry and to prescribe dangerous drugs, (a) cannot we be trusted to prescribe liquors as medicines when we as individual physicians feel that it is needed? And (b) we are constrained by one of the oldest of traditions, certainly the oldest in medicine, and almost bound by the Hippocratic Oath, which we all have taken, to reveal nothing regarding the patient's illness which in any way might be detrimental to him or to his family.

Whatever our personal attitude on the need of liquors may be, we cannot, at least should not, calmly say that the trials of our associates in other states is none of our business. If that is our attitude then the effort put forth, for so many years, to make organized medicine and fraternal relations mean something, has been a useless expenditure of time and energy. If we in Florida are to adopt a position of indifference to our associates' trials and never raise a voice in protest, we are not the open-minded, clear-seeing ministers to the suffering and the unfortunates that we are supposed to be. Can we afford to ignore and laugh at the burden placed upon our brothers in medicine? A most sordid attitude!

The least we can do is to appeal to those, our representatives, who helped to impose a disagreeable burden upon the medical profession, to, if only in the spirit of fair play, review their act and give the ones who placed them in a position of power the opportunity to once again register their will.

(Signed) G. H. EDWARDS, M.D.

PATRONIZE JOURNAL ADVERTISERS

Advertisers in our Journal bear the stamp of approval of the American Medical Association and also of the Florida Medical Association. They are worthy of the patronage of our members.

PERRY SCHOOL TOOTH BRUSH DRILL

The following report has been received from Walton H. Y. Smith, M.D., director of the Taylor County Health Unit:

As a result of the physical examinations of 1,735 school children in Taylor County, it was found that 934, or 53.83%, of the children examined had defective teeth. These 934 children had 3,276 decayed teeth, or an average of 3½ decayed teeth to a child. As physical examinations were continued through the school year, with the figures for decayed teeth gradually mounting, it became apparent that something ought to be done to get the children "tooth conscious." Since the average daily attendance of Perry school was 967, or about one-half of the total, white, school population of the county, it was decided to have the tooth brush drill there. A survey was made of the first four grades to determine the number of children who had tooth brushes. Out of the 467 pupils, one-fourth of them did not have a tooth brush and were unable to buy one. A few of these children were trying to clean their teeth with clean rags. The Perry Rotary Club donated enough money to buy a tooth brush for each poor child. The other children who had tooth brushes were asked to bring them on a certain day.

On the morning of that day the free tooth brushes were distributed and a sample of tooth powder was given to each of the 467 children. They were then shown a motion picture called "Tommy Tucker's Tooth." This is a silent picture and is the story of two school boys, one who brushes his teeth and one who does not. Both boys are looking for jobs during the summer vacation and the boy with the clean teeth gets one while the boy with the dirty, decayed teeth is given a lecture by the prospective employer about his teeth. He is told to visit his dentist, the boy's best friend. The advice sinks in and the youngster makes haste to the dentist and reports to the employer later when his teeth are fixed and he, too, gets a job. A break in the story occurs to show the correct method of brushing teeth. A large set of false teeth are brushed. When this part of the picture was shown the moving picture operator slowed the machine as much as possible. This tooth brushing part of the picture was shown again, this time the children and teachers brushing their teeth with the picture. It was essential for the teachers to do this in order for them to learn the proper technique to teach at the subsequent practices.

Three short songs were practiced, one telling about "Brushing Your Teeth," one depicting "Brushing Your Teeth," and one showing "How We Smile After We Brush Our Teeth." Each teacher instructed her class and practiced with them daily in brushing their teeth. Four practice drills with all the children were held. The fifth drill was the final one and at this time a still picture was taken.

The tooth brush drilling had its effect, for many children began brushing their teeth who had never done so before. Many children took more interest in tooth brushing and a certain amount of "tooth consciousness" became manifested.

This drill was made possible by the active cooperation of the Perry Rotary Club, Miss Gladys Morse, the principal, her teachers, and Mrs. M. E. Herndon, the County Health Nurse.

STATE NEWS ITEMS

President Gerry R. Holden called a meeting of all councilors, members of the Executive Committee and members of the Committee on Legislation and Public Policy on June 12th at Jacksonville. The Committee on Legislation and Public Policy met at 10:00 a. m., the Executive Committee at 11:00 a. m., and the Councilors at 12:00 noon. A general luncheon meeting was held at 1:00 p. m. All past presidents were invited to attend the general luncheon meeting and a number of them were present and took part in the discussions, adding their counsel and advice. The assembling of the committees and councilors proved very helpful and will undoubtedly be a stimulus in the activities of the ensuing year.

At the meeting of the councilors, Dr. Ralph N. Greene of Jacksonville was elected chairman and Dr. Shaler Richardson, Jacksonville, secretary. The councilors from the various districts now form what is known as our "Council." With their duly elected chairman and secretary, they are organized in a manner that will make possible a very definite step in organized medicine and should prove very helpful in many lines of activities that are now contemplated. The following resolution was presented and passed by the Council, and the secretary was instructed to forward

copies to our senators and representatives in Washington:

"WHEREAS, the present laws, regarding the hospitalization and treatment of veterans are not equitable, are burdensome and contrary to the interests of the people in this state, and

"WHEREAS, changes in the legislation are required to correct the present defects,

"BE IT THEREFORE RESOLVED, that the hospitalization and care and compensation of veterans for other than service-connected disabilities under Section 202 (10), World War Veterans Acts, 1924, as amended, is an unnecessary and unfair burden to place upon the taxpayers of this country and should be eliminated."

One important item of business taken up by the Executive Committee was in connection with the action of the House of Delegates at the Sarasota meeting, relative to honorary memberships. After a thorough investigation, the Executive Committee approved for honorary membership, Dr. Louis S. Oppenheimer of Tampa and Dr. George C. Johnston of Orlando. After careful consideration of the application of Dr. Wm. H. Cox of Brooksville, the Committee voted that Dr. Cox was not eligible for honorary membership, as he had not been a member of the Florida Medical Association for the past sixteen years.

Those who attended the meeting officially were:

Gerry R. Holden, president, Jacksonville; Shaler Richardson, secretary, Jacksonville; Stewart Thompson, business manager, Jacksonville.

Executive Committee: O. O. Feaster, chairman, St. Petersburg; Leigh F. Robinson, Ft. Lauderdale; W. H. Spiers, Orlando.

Committee on Legislation and Public Policy: S. E. Driskell, Jacksonville; H. E. Palmer, Tallahassee; C. E. Tumlin, Miami.

Councilors: Ralph N. Greene, chairman, Jacksonville; T. H. Bates, Lake City; H. D. Clark, Ft. Pierce; Geo. R. Creekmore, Brooksville; M. J. Flipse, Miami; John S. Helms, Jr., Tampa; Elliott M. Hendricks, Ft. Lauderdale; J. M. Hoffman, Pensacola; D. A. McKinnon, Marianna; Meredith Mallory, Orlando: E. W. Warren, Palatka; Walter A. Weed, Lakeland; J. Ralston Wells, Daytona Beach.

Past Presidents: L. M. Anderson, Lake City; H. C. Dozier, Ocala; G. H. Edwards, Orlando; J. H. Hodges, Gainesville; Wm. E. Ross, Jacksonville; H. Marshall Taylor, Jacksonville.

Dr. Gaston Edwards, past president of the Association, Orlando, returned recently from New Haven, Connecticut, where he attended the Yale University reunion. Dr. Edwards stopped for a brief visit in Jacksonville between trains, and conferred with Dr. Gerry R. Holden, president of our Association.

* * *

Dr. Frederick K. Herpel of West Palm Beach recently motored to North Carolina, with his two sons, Henry and Billy. The boys will spend two months at Camp Quoyha in North Carolina.

* * *

Dr. and Mrs. I. M. Hay of Melbourne were recent visitors in St. Augustine.

* * *

Dr. and Mrs. M. P. DeBoe of Miami spent ten days in Key West during the month of June.

* * *

Dr. B. E. Miller of New Smyrna spent several days in New Smyrna recently, where he visited his mother and brother.

* * *

Drs. Charles E. Creel and Geo. Ellarbee of Pahokee were in charge of a typhoid immunization clinic held at the Pahokee High School building, Friday, June 24th.

* * *

Dr. and Mrs. S. J. Simmons of Clewiston visited for several days in Arcadia last month.

* * *

Dr. P. M. Lewis of Orlando was a visitor in Atlanta during the month of June.

* * *

Dr. O. G. Kendrick, Tallahassee, was one of the principal speakers at the Kiwanis luncheon at its first meeting in June.

* * *

Dr. J. R. Chappell of Orlando recently proposed a permanent free clinic to be operated daily. The plan has been endorsed by the Orange County Medical Society.

* * *

Dr. Robert M. Baker of Jacksonville was a visitor in St. George, Virginia, recently.

* * *

Drs. J. T. Bowen, W. H. Groves and F. E. Kaufman of Clearwater made examinations of forty-six children at the annual summer round-up clinic conducted by the Parent-Teachers' Association recently in the Clearwater schools.

Dr. and Mrs. L. W. Blake of Bradenton were hosts at a fish fry to the members of the Rotary Club on June 9th at their beach home at Anna Maria.

* * *

Dr. Clayton E. Royce, Jacksonville, was the principal speaker at the Rotary Club, June 7th.

* * *

Dr. M. H. Moeller and children of St. Petersburg spent the month of June vacationing at Daytona Beach.

* * *

Dr. J. E. Rawlings of Daytona Beach was a representative from General Lawton Camp 15, Spanish War Veterans, to the annual reunion at Hollywood, June 5-8. Dr. Rawlings was elected department surgeon for the Florida S. A. W. V. at the meeting.

* * *

Dr. Chas. L. Park of Sanford was recently appointed to the staff of physicians and surgeons comprising the Sanford Clinic, with offices in the Masonic Temple. Dr. Park has moved his office from the First National Bank building. With Dr. Park's addition, the clinic now has four physicians and surgeons: Drs. Park, S. Puleston, R. E. Stevens, and J. N. Tolar.

* * *

Dr. V. D. Stone of West Palm Beach was the principal speaker before the Rotary Club the early part of June. Dr. Stone's subject was "Preventive Medicine."

* * *

Dr. B. Y. Pennington of Lake Wales recently made a trip to Opelika, Ala., where he joined his family. He will spend a short vacation there before returning home.

* * *

Dr. Robert D. May and family of Jacksonville spent the month of June at their cottage at Atlantic Beach.

* * *

Dr. L. A. Peek of West Palm Beach was the principal speaker before the Civitan Club's regular weekly luncheon, May 23rd.

* * *

Dr. E. C. Aurin of Arcadia was elected county commissioner of the fifth district.

* * *

Dr. E. B. Hardee of Vero Beach returned recently from a trip to the north, visiting Long Island and several points in North Carolina.

Dr. Raymond Sanderson of Jacksonville spent two weeks at Fort Screven, Georgia, in the citizens' military training camp last month.

* * *

Dr. D. M. Adams and sons, Powell and D. M., Jr., of Panama City, enjoyed a camping trip at Beacon Hills recently.

* * *

Members of the West Palm Beach Rotary Club were guests of the Good Samaritan Hospital Association the latter part of June. Dr. Frederick K. Herpel, president of the club, was in charge of the program. Dr. W. L. Shackelford is superintendent of the hospital, Dr. R. O. Cooley, chief of staff, and Dr. V. M. Johnson, bacteriologist.

* * *

Several scholarships to the Southern Pediatric Seminar, to be held at Saluda, North Carolina, July 25 to August 6, are available to Florida doctors. Any one desiring a scholarship should communicate with Dr. D. Lesesne Smith, Secretary, Duval County Hospital, Jacksonville.

* * *

Dr. T. F. Jackson of Dade City, attended the clinic of Emory University Medical School, Atlanta, from June 6th to 10th. He was unanimously elected president of the Emory Alumni Association for the year 1932.

* * *

Dr. and Mrs. E. W. Veal of South Jacksonville are spending several weeks at Jacksonville Beach. Dr. Veal is maintaining his usual office schedule in Jacksonville.

* * *

Dr. T. H. Wallis of Ocala attended the international meeting of Kiwanis in Detroit the last of June. Dr. Wallis attended Dr. Crile's clinic in Cleveland, en route.

* * *

Dr. Henry E. Palmer, Tallahassee, was the principal speaker at the local Kiwanis Club luncheon recently. Dr. Palmer's subject was "The Under-Privileged Child."

* * *

The annual meetings of the Duval County Tuberculosis Association and Hope Haven Association, Inc., were held jointly at the Mayflower Hotel, Monday evening, June 6th. Dr. Thomas M. Palmer read a paper on "The Medical Care of Children of Hope Haven." Dr. F. L. Fort read a paper on "The Crippled Child at Hope Haven."

The American Board for Ophthalmic Examinations will hold an examination in Montreal on Monday, September 10th, at the time of the meeting of the American Academy of Ophthalmology and Otolaryngology. Necessary applications for this examination can be procured from the Secretary, 122 South Michigan Boulevard, Chicago, and should be sent to him at least sixty days before the date of the examination.

* * *

Dr. T. H. D. Griffitts, surgeon for the United States Public Health Service, has been relieved from duty at Albany, Ga., and assigned to duty at Jacksonville, to establish headquarters in connection with field investigations of malaria.

* * *

Dr. Frank C. Metzger of Sarasota is now located in Tampa, having closed his Sarasota office on July 1st.

* * *

Dr. F. D. Gray of Orlando attended the meeting of the Georgia State Medical Association at Savannah during the month of May.

* * *

Dr. George S. Stone of Ft. Myers died on June 1st, after an illness of ten days. Dr. Stone was president of the Lee County Medical Society.

* * *

On May 20th, a committee from the Florida Department of the American Legion was given a hearing by General Frank T. Hines, Administrator of Veteran Affairs, Washington, D. C. The committee, of which Dr. T. H. Bates of Lake City was the medical member, presented arguments and plans for needed improvement and repair at the Veterans' Hospital, Lake City. After the hearing, the Federal Hospital Board recommended the construction of a new clinic building and staff officers' quarters, the cost of which will approximate $200,000.

* * *

Dr. William S. Nichols of Lake City and Miss Marie Eleanor Haile of Live Oak were married on June 28th.

* * *

Dr. Hugh West of DeLand left Florida in June, en route to Vienna where he expects to take special work in general surgery and gynecology. He will return some time in September.

Dr. O. O. Feaster of St. Petersburg is now located at the St. Anthony's Hospital, having moved his office from the Power and Light Building.

* * *

Dr. Ernest B. Milam of Jacksonville attended the international convention of Kiwanis, held in Detroit, the latter part of June. Dr. Milam heads the committee on international education.

* * *

Dr. and Mrs. Thos. W. Hutson of Miami returned recently from Tampa where Dr. Hutson attended the meeting of the State Board of Medical Examiners.

* * *

Dr. and Mrs. W. S. Miller of Palatka motored to St. Augustine for a week-end visit the latter part of June.

* * *

Dr. and Mrs. O. W. Gardner of Greensboro had a recent visit from their daughter, Miss Eloise Gardner, who has been teaching in the Miami schools.

* * *

Dr. and Mrs. W. T. Langley of Sanford enjoyed a short vacation at Daytona Beach last month.

* * *

The American Public Health Association has formally recognized the Florida Public Health Association as an affiliated society. Official notification was recently received from Dr. Kendall Emerson of New York, the acting executive secretary of the A. P. H. A. Dr. Stewart Thompson is secretary-treasurer of the State Association.

* * *

Dr. and Mrs. F. P. Key, Green Cove Springs, spent a two weeks' vacation at St. Augustine Beach during the month of June.

* * *

Dr. and Mrs. Clayton Washburn of Jacksonville recently made a trip to Ithaca, N. Y., to attend the wedding of their daughter, Ruth, and Mr. E. Stewart Williams, which occurred on June 21st, in Sage Chapel. Miss Washburn and Mr. Williams graduated from Cornell University on June 20th.

* * *

Dr. and Mrs. H. W. Henry of New Smyrna spent a few days in St. Augustine recently.

Dr. Robert D. May and family of Jacksonville spent the month of June at Atlantic Beach.

* * *

Dr. W. C. Box, Graceville, died Sunday, June 12th. Dr. Box had been in failing health for several months.

* * *

Dr. and Mrs. C. H. Ryals of Grand Ridge, recently had as their guest Dr. Will Ryals of Alabama, a brother of Dr. C. H. Ryals.

* * *

Dr. W. L. Wood of Mt. Dora recently inaugurated an anti-mosquito campaign in and around that city.

* * *

Dr. J. J. Saxton of Tampa was recently appointed assistant city health officer.

* * *

Dr. S. G. Hollingsworth of Bradenton attended the semi-annual meeting of the State Board of Medical Examiners held in Tampa, June 13-14.

* * *

Dr. and Mrs. H. Marshall Taylor of Jacksonville are spending the summer at their cottage on the ocean front at Atlantic Beach.

* * *

At the recent meeting of the State Board of Medical Examiners, held in Tampa June 13-14, Dr. Carl Williams of St. Petersburg was elected president of the Board. Dr. Williams succeeds Dr. Thos. W. Hutson of Miami. Dr. J. D. Raburn, Trenton, was elected vice-president, and Dr. W. M. Rowlett, Tampa, secretary-treasurer.

* * *

Dr. and Mrs. G. C. Bottari of Tampa are spending the summer at their cottage at Indian Rocks.

* * *

Dr. and Mrs. R. O. Lyell of Miami attended the opening session of the East Coast Assembly at Hollywood, June 21st.

* * *

Dr. and Mrs. R. E. Stevens of Sanford were visitors in Jacksonville recently.

* * *

Dr. B. A. Wilkinson of Tallahassee spent a week at Lanrk recently.

* * *

Dr. Richard S. Gill of West Palm Beach made an extended trip through Virginia during the month of June. He spent some time at the University Hospital at Charlotteville and other hospitals of the state.

Dr. J. Maxey Dell, Jr., of Gainesville returned on July 1st from Atlanta. He will be associated with his father, Dr. J. Maxey Dell, in the practice of medicine.

* * *

Dr. and Mrs. H. Rutter made an extended motor trip through the north on their vacation. They visited relatives at Darlington, Md., en route.

* * *

Dr. H. Quillian Jones of Ft. Myers recently deserted his medical work long enough to catch a forty-pound tarpon, the night of June 23rd, on the Caloosahatchee.

* * *

Dr. J. N. Fogarty of Daytona Beach recently visited his old home in Key West.

* * *

The annual meeting of the Staff of the Orange General Hospital, Orlando, took place at the hospital Monday evening, June 6th. The officers elected for the ensuing year were: Dr. William H. Spiers, president; Dr. J. R. Chappell, vice-president; and Dr. Henry Gwynn, secretary and treasurer. It was again voted to continue the prizes for the three best nurses in the graduating class and a committee was appointed, consisting of Drs. J. S. McEwan, J. H. Chiles and Hewitt Johnston, to canvass the records to determine which three graduates were eligible for these prizes. A resolution was adopted, recommending to the Governing Board that all physicians who are now members of the Orange General Hospital Staff, but who persist in taking their patients to hospitals in Orlando which are not recognized by the Hospital Association, and whose owners are not members of the Orange County Medical Society, be barred from bringing their patients to the Orange General Hospital.

COMPONENT COUNTY SOCIETIES

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its June meeting at the Mayflower Hotel, Jacksonville. Dr. H. M. Taylor read a very interesting paper on "The Hygiene of Swimming", with special reference to the cause and prevention of sinus and ear infection. His talk was illustrated by a moving picture film showing the adaptations of air breathing acquatic animals which adaptations are lacking in man. Dr. Taylor has made a real contribution to the world's knowledge of biology and physiology on the subject.

ORANGE COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Orange County Medical Society was held June 15th, at the Orange General Hospital, with Dr. G. S. Osincup presiding. Dr. C. J. Marshall was the principal speaker of the evening. With the aid of his stereoptican machine, he gave an illustrated discussion on "Syphilitic, Tuberculous and Carcinomatous Skin Lesions." A report of the Orange County Society members' activities in the health improvement work of the high school was presented. A report was made by the Board of Censors regarding activities of various members in advertising and a resolution was presented covering that activity; penalizing by expulsion members who failed to live up to the Society's ideas of advertising ethics. The resolution was adopted and a committee appointed to draft a by-law covering that phase of county society activities. A report was given by the committee appointed to take under advisement the establishing of an Orange County Medical Society Clinic for the benefit of the indigent. The Junior Welfare League is as interested in the establishment of this clinic as the members of the Society. The report was approved and the committee continued to further its plans.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. T. F. Jackson of Dade City was host to the Pasco-Hernando-Citrus County Medical Society on the evening of May 19th. Dinner was served at the Edwinola Hotel and the scientific meeting took place in the parlor of the hotel. Dr. L. T. Furlow, Brooksville, vice-president, called the meeting to order. Dr. T. F. Jackson, delegate to the Florida Medical Association meeting in Sarasota, gave a splendid report on the proceedings of the meeting. After interesting discussions and impromptu talks, the meeting adjourned.

VOLUSIA COUNTY MEDICAL SOCIETY

The Volusia County Medical Society and the Auxiliary to the Volusia County Medical Society held an annual picnic at DeLeon Springs on June 21st. The affair was the last get-together meeting of the summer. Society meetings will be resumed in the fall.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, Inc.

State Editor

Mrs. S. E. Driskell

1410 Windsor Place

Jacksonville, Florida

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REPORT OF THE NEW ORLEANS CONVENTION

Mrs. J. Ralston Wells

When I left the Auxiliary convention in Philadelphia last June, I thought, "There can never be another such meeting," but when I left New Orleans last month, I was forced to acknowledge, "There is no limit to what we can do."

True, the attendance was not so large, approximately 850 women in all, but the same enthusiasm was there, the same efficient arrangements, the same business-like procedure, and, above all, permeating everything, the veritable flower of Southern hospitality.

Activities began with the Executive Board dinner on Monday evening, May 9th. This was held at the Orleans Club, a transformed but typical Southern home. The long table, seating over thirty women, was decorated by clusters of magnolias down its entire length, with a gardenia at each plate. And the food for which New Orleans is famous made us linger long at table. The Board meeting which followed, moved along smoothly under the able guidance of Mrs. McGlothlan, and the necessary business, which is by no means small, was easily transacted. It was inspiring to find the Auxiliary growing, not only in membership and finances but also in purpose and fulfillment.

Heretofore I have been the only Florida representative at these Executive Board meetings, but this year Mrs. Leigh F. Robinson, our new president, most ably represented our State, and she and I tried to cover every phase of Auxiliary

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DR. ALBERT F. BRAWNER, Resident Physician.



HOLLYWOOD BEACH HOTEL

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Oscar T. Johnson, *Manager*

activities in order to pass on to you members at home the information we could obtain.

We were not the only Florida women at the convention, however. There was a good representation of both Auxiliary members and others. My list is by no means complete, but I want to mention Mrs. Herrman Harris of Jacksonville, Mrs. Arthur Walters of Miami Beach, Mrs. Martin of Sebring, Mrs. Quillian Jones of Ft. Myers, and Mdmes. Feaster, Langley, Timberlake, and Knowlton of St. Petersburg.

All sessions of the Woman's Auxiliary were held in the Jerusalem Temple. The Tuesday and Wednesday morning sessions were presided over by Mrs. McGlothlan. The reports of officers and committee chairmen, followed by State reports on the second day, showed how the Auxiliary had increased in interest and ability under the able leadership of the National President. We are now an organization which functions in every department.

Preceding the general meeting on Thursday, at which Mrs. Freeman, the new president, presided, there were held a series of conferences on Administration and Archives, Program and Hygeia, Press and Publicity, and Public Relations. These are the very meat of the convention, and are the best means of obtaining personal information on what the other fellow is doing and how he does it.

But the charm of New Orleans overshadows convention proceedings. Everything was provided for the entertainment of the visitors. The walk through the Vieux Carré and tea at the Patio Royal; the luncheon at the Southern Yacht Club on the shores of Lake Pontchartrain, followed by tours of private gardens; the evening entertainment at the Country Club, with interpretative dancing showing the growth of medicine through the ages, negro spirituals under a spreading live oak where guests stood around in the moonlight listening to the eerie voices; tea at the Petit Salon with Dorothy Dix presiding; all kinds of trips, all kinds of fun. Can you blame me if I have the convention habit?

* * *

The Florida women officially affiliated with the National Auxiliary are as follows: Mrs. J. R. Wells, Daytona Beach, director for two years; Mrs. H. H. Harris, Jacksonville, member of the Hygeia committee; Mrs. S. E. Driskell, Jacksonville, regional chairman of press and publicity.

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And when he takes your temperature or blood-pressure, when he examines your nose and throat and ears, when his skilful, gentle fingers search for a tender spot in your abdomen —when he does all these things, he is employing scientific methods whose usefulness in revealing your body's secrets has been developed by decades of study and experience. But only the trained eye and ear and hand of your physician can *use* them scientifically.

Your doctor is trained to recognize and cure disease. Make use of his experience and ability. Far too many people suffer needlessly as the result of well-intentioned but unscientific advice of friends and neighbors. When you feel ill, get *professional* advice—call your doctor without undue delay.

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Those particularly who had the privilege of getting to know our National President—Mrs. Walter Jackson Freeman—during her recent visit to our State will sympathize with her in the loss of her distinguished father, Dr. William Williams Keen, who died in Philadelphia on June 7th at the age of 95 years.

* * *

On account of illness, Mrs. J. M. Irwin felt she could not continue as state historian and Mrs. Wilburn Lassiter of Gainesville has been elected to carry on this work so ably started by Mrs. Irwin.

This is a most appropriate choice, as Mrs. Lassiter was the chief organizer and first president of the State Auxiliary.

ADVERTISERS' NOTES

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The American Medical Association
Committee on Foods

Cocomalt contains not less than 30 Steenbock (300 ADMA) Units of Sunshine Vitamin D per ounce and is licensed by the Wisconsin Alumni Research Foundation under Steenbock Patent No. 1,680,818. Cocomalt is an appropriate vehicle for Vitamin D because Cocomalt carries along with Vitamin D a large supply of organic mineral salts which are biologically favorable in their proportion of calcium and phosphorus.

Cocomalt is highly recommended for children, adults, expectant and nursing mothers and convalescents. This recommendation carries with it an official note of authority because Cocomalt has the endorsement of the American Medical Association, Committee on Foods.

"When, As and If"

the bottle-fed baby exhibits symptoms indicating partial vitamin B deficiency—described by Hoobler as (1) anorexia (2) loss of weight (3) spasticity of arms and legs (4) restlessness, fretfulness (5) pallor, low hemoglobin, etc.

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Soft Curd Milk

Recent interest in soft curd milks has turned more attention to the kinds of curds formed in the stomach of the infant by cows' milk and modified formulas.

A synopsis of the work done up to the present time has been made by Professor R. M. Washburn in an article entitled "Soft Curd Milk" published in the December, 1931, number of "The Milk Dealer." He points out that according to one series of tests, the lowest values for soft curd milk range from 14 to 34; the average from 53 to 69; and the highest from 107 to 116.

Even these lowest values for cows' milk are very high compared with human milk which shows a curd tension in the neighborhood of zero, as does also S. M. A.

It is gratifying to officials of S. M. A. Corporation to note that more attention is now being given to the characteristics of the curds. In 1921, when S. M. A. was offered in response to the demand of physicians, there was not the general understanding of the importance of the fact that S. M. A. forms soft curds very similar to breast milk.

Ephedrine Indications

Inflammatory changes anywhere in the nasopharyngeal tissues tend to lower the defensive mechanism of the mucous membrane. The purpose of local treatment is to aid nature in restoring normal physiological function. The use of ephedrine, therefore, seems definitely indicated, because it reduces congestion, permits improved respiratory ventilation, diminishes the absorption of toxins, and promotes ciliary activity and drainage. The results of this therapy add materially to the comfort of the patient and tend to prevent the development of secondary infections.

To meet every condition of local application, Eli Lilly and Company offer a wide selection of ephedrine products, including a solution, inhalants, jellies, and ointment. Ephedrine Inhalant No. 21, Plain, contains 1.0 per cent ephedrine in a light, neutral mineral oil without other ingredients; the Compound Ephedrine Inhalant, No. 20, contains, in addition, camphor, menthol, and oil of thyme. All Lilly Products enjoy widespread distribution and are quickly available through the drug trade.

Ground was recently broken for the erection of a research laboratory building at the works of Merck & Co., Inc., at Rahway, N. J. The project has been under consideration for some time. George W. Merck, president of the Company, brought it to the attention of the stockholders a year ago. The directors have authorized proceeding with the work at this time, moved by the consideration that it will provide increased employment and that the facilities are urgently needed. The research activities of the Company are at present being carried on in various parts of the large Merck plant—in many cases in make-shift quarters.

The building will be a Colonial type, brick structure, with a central section 40 ft. by 80 ft., of two stories and basement. On each end of this central section will be two one-story wings, 50 ft. by 100 ft. The wings will be connected with the central section by two one-story units, 10 ft. by 38 ft.

Merck & Co., Inc.'s, decision to carry out such an ambitious plan at this time adds another to the growing list of American chemical companies who have determined not to allow the period of depression to diminish their activities in research and technical endeavor. It is interesting to observe the manner in which the forward-looking companies are meeting the present situation, as contrasted with the all too prevalent attitude during 1921, which in particular affected chemical companies adversely and led many to discontinue research staffs and abandon all development work. Dr. Hugh Taylor, head of the Chemical Department at Princeton University, recently took occasion to point out that the continued pursuit of scientific investigation by industrial concerns is one of the most encouraging signs in these times.

DRUG ADDICTS

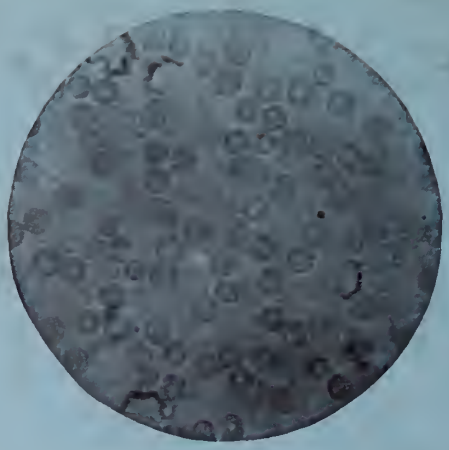
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	
Bay	D. M. Adams, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital	No.	
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	Louis Orr, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	V. M. Johnson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	No.	
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg	Every other Thurs.	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. C. Patterson, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	
Washington-Holmes						

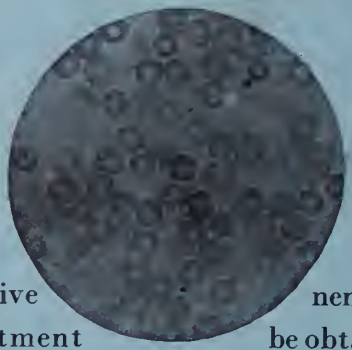
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VOLUME XIX
NO. 2

Jacksonville, Florida, August, 1932

Yearly Subscription, $3.00
Single Copy, 30c

THE N.Y. ACADEMY OF MEDICINE
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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

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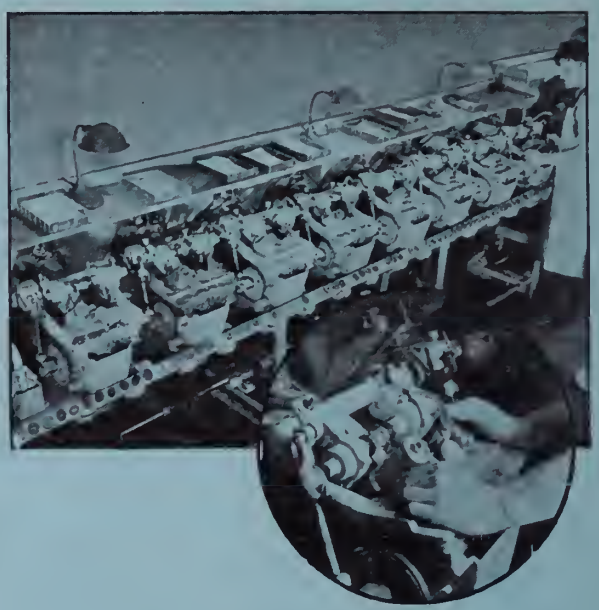
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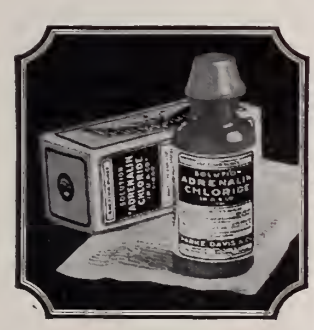
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ROBERT G. NELSON, M.D.,
Tampa.

The greatest advancement in obstetrics during the past decade has had to do with the perfection of methods intended to relieve pain and anxiety during labor. The ease with which labor can now be accomplished stands in marked contrast to the agony formerly attending childbirth. Safe methods have been developed whereby the suffering of the entire labor can be practically eliminated, and painless or comfortable labor has become an actuality. While there may be a difference of opinion as to the merits of individual methods, yet, in principal, they have been universally accepted.

The amelioration of labor pains is not a new subject to the medical profession. The use of narcotic drugs for the relief of labor pains is related in ancient medical history. Ether inhalation anesthesia was first used by Sir James Y. Simpson in 1847, and during November of the same year he was the first to use chloroform. Nitrous-oxide has been used since 1878. While inhalation anesthesia is still to be relied upon in operative obstetrics, and during the latter part of the second stage of labor, its use during the first stage is not practical. It is needless to call your attention to the dangers and sequella of the prolonged administration of inhalation anesthesia.

In 1902, Steinbuchel introduced the use of morphin-scopolomin in his so-called "Twilight Sleep." This method created quite a furore, its results being heralded far and wide. It was introduced into this country in 1913, and through articles appearing in lay magazines it was brought to the public as a panacea for all the ills and discomforts attending childbirth. In this way its use was really forced on the medical profession. As statistics accumulated in various medical centers, where it was being used, it was soon learned that the marked increase in infant mortality, as well as a definite increase in the maternal mortality, made it an unsafe method for general use. Today, it has practically been discarded.

In 1923, a decided advance was made by Gwathmey when he introduced the use of morphin-magnesium sulphate intramuscularly, combined with the rectal installation of an ether oil mixture. With minor changes in technique this method has been widely used, and the results have been far superior to those obtained through the use of any other drug or anesthetic. It has been used almost exclusively at the New York Lying-In Hospital, where they report considerable amelioration of pain in over 75% of cases. My own experience would indicate, however, that it causes a definite prolongation of labor, and that some inhalation anesthesia is practically always necessary at the time of delivery.

In an effort to eliminate the use of morphine, McNeile & Vruwink reported during 1927 the use of "Dial" intramuscularly in conjunction with Gwathmey ether oil mixture. This, together with reports from the Mayo Clinic on the use of sodium amytol intravenously in surgery, attracted my attention to the possibilities of the barbituric acid derivatives as a means of alleviating labor pains. Sodium amytol was used in a series of ten cases, the results, so far as analgesia is concerned, were satisfactory. The patients, however, were inclined to be rather restless, and, at times, were difficult to handle. Dial was then used in a series of a hundred and ten consecutive cases. The results have been so uniformly satisfactory that I am prompted to report in some detail the effects obtained from this valuable drug.

After using various plans as to dosage and time of administration the following plan of procedure has been adopted. The first dose of 2 cc. is given as soon as labor is established, irrespective of the amount of dilatation. A second injection of 2 cc. is given at an interval varying from thirty minutes to one and a half hours later, depending on the rapidity and force of the labor pains. If labor is of short duration and the patient small of stature two doses will be sufficient. More often, however, a third dose of 2 cc. will be necessary, this to be given about thirty minutes before anticipated delivery. In two cases only was it necessary to give the fourth dose. In both instances, the patients were of large stature,

*Read before the 59th Annual Meeting of the Florida Medical Assn., Sarasota, May 3, 4, 1932.

and labor was prolonged, due to posterior presentation. The drug is administered intravenously, using a small hypodermic needle and given very slowly. Occasionally, the patient will complain of a burning sensation up the arm during the administration of the drug. It is important that none of the drug be allowed to enter into the subcutaneous tissue, as an area of inflammation may result.

The systemic action of "Dial" is practically limited to the central nervous system, particularly to the brain and cord. The peripheral sensory and motor nerves are undisturbed. The sensory cortex is more depressed than the motor. Reflexes are depressed before the pain sense is affected. The special senses are rarely affected, except there may be pupillary dilatation, and loss of light reflex. Even in toxic doses there is no disturbance of the digestive function. The heart is not influenced. Peripheral blood vessel dilatation may occur, leading to sweating, and slight lowering of blood pressure. During the administration of the drug, or shortly thereafter, the patient may experience a sense of dizziness, which soon passes off. Often after the second dose, and almost invariably after the third injection, the patient will complain of double vision. The double vision, when experienced, will last eight to twelve hours. The blood pressure drops ten to fifteen points and the pulse rate often slows down five to ten beats per minute. After the second dose the patient usually sleeps soundly between pains, but at all times may be aroused. When aroused she will converse intelligently with you and will respond to requests. Often you will not realize, until the day following delivery, how wonderful the analgesia has been. You will usually find that the patient remembers little or nothing about the confinement.

I have observed no contraindications to its use. It can be used without fear of an ill effect on either the mother or baby. It relieves pain during labor, strengthens uterine contractions, decreases the interval between contraction, and promotes relaxation of the perinium. Labor is materially shortened, both in multipara and primipara. It is no longer necessary to use morphine or other opiate derivatives, and as a result I have not had to resuscitate a single baby. In the entire series, there has not been a maternal or foetal mortality, the only death being one still-born monster. We have done many difficult procedures, such as forceps, versions and extractions, episiotomies, and necessary repair without the necessity of additional anesthetic.

Summary: To me the above described method has decided advantages over other methods of alleviating the pains of labor: first, its simplicity of administration; second, the acceleration rather than retardation of labor; third, its lack of danger or ill effect on either the mother or baby; fourth, its lack of contraindications; fifth, its apparent relaxing effect on the perinium; and sixth, the pronounced rest and relaxation obtained after delivery.

Conclusion: What is to be the obstetrician's reward for making labor easy? Dr. Arthur H. Bill of Cleveland answers this question in his Presidential address before the forty-fourth annual meeting of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons. He says, "It must always be a secondary consideration. It cannot be expected that the obstetrician who adopts the methods of the new school will endear himself to the hearts of his patients as did the physician of the old school, who sat by his patient through the intense suffering, having as his chief armament patience, and encouragement, and who, only as a last resort, delivered the baby and ended the ordeal. Appreciation comes mainly by contrast, and prophylaxis never impresses the patient's mind as much as cure. When a patient is carried through a labor in a state of practical oblivion, and really has no knowledge of what a genuine labor is like, she cannot appreciate the worth of such treatment, as does the patient who is relieved after long suffering. The obstetrician's reward must be largely his personal satisfaction in the realization that he has been able to conduct comfortable and, at the same time, safe labors, and thereby save the women of today the tortures of our mothers."

DISCUSSION

Dr. Samuel R. Norris, Jacksonville:

I want to state in the beginning that I have never had any personal experience with Dial used as a routine in labor. I have used some of the other barbituric acid derivatives with about the same results given by other physicians in published reports. There is a certain amount of amnesia, but also at times a great deal of restlessness in the patient.

But, first, I want to congratulate Dr. Nelson for his original work. So far I have seen no

other reference in literature to the use of Dial in obstetrics, that is, routinely.

There are several things to take into consideration in using any analgesia, hypnotic, or anesthesia in childbirth. The first is safety—safety to both mother and baby. The relief of pain is secondary. The minute safety to either one is endangered, then we must stop. We use the various analgesia, hypnotics, etc., to stop pain from a humanitarian standpoint; again to prevent exhaustion so that our patient is less liable to have postpartum hemorrhage, infection and other consequences of a lowered resistance; to prevent the psychic shock and fear of future labors; and to enable us to perform various obstetrical maneuvers that might be indicated.

Many papers have been presented, various drugs recommended and extolled, all claiming to do all the things mentioned above, but so far none have proven ideal or lived up to the advance claims. They all should be given a fair trial and be put on record for it is only by such zeal and ambition as shown by the many essayists, by trial and error, will we ever reach the ideal. But we must be cautious not over-optimistic, impartial, ready to admit defects as well as advertise the virtues. But always remember safety first.

One other thing. The success of any drug or any method depends largely upon the doctor using it. The more familiar the better his technique the better results obtained. This comes from experience and requires constant personal attention throughout labor. Any drug powerful enough to cause complete amnesia to carry patient throughout labor without pain, to give enough relaxation to permit various abnormal deliveries, requires a physician to be in constant attendance upon that patient. It would neither be wise nor safe to give such drugs and then leave that patient alone with family or nurse.

I think Dial should be given a further trial. I want to know more about it. Although I do not believe any one drug or method can fit every type of case this should be added to the ever-growing armamentarium we have at our disposal to lessen the dangers and mitigate the pain and ordeal of labor.

Dr. W. M. Rowlett, Tampa:

Dr. Nelson is to be congratulated upon the presentation of this interesting paper. I personally know that he has devoted a great deal of painstaking time to the study of the alleviation of pain in labor.

Since time immemorial, the physician has endeavored to erase that evil wished upon Eve, by trying to find something that would subdue pain during childbirth. Pain is the greatest curse to the human race, and the havoc it has produced to the modern young mother is too frequently underestimated. I feel that it is the duty of every physician to ameliorate the torture of labor as far as it is possible to do so without endangering the life of the mother or baby.

When judiciously used in a hard, prolonged labor, an analgesic relaxes the muscles of the uterus, which has a most beneficial effect upon the baby, and no doubt has been the means of saving the life of a great many of them.

Like most all good things, anesthetics are not without their toll. Every patient is an individual problem, and no general rule can be adopted in the administration of analgesics. It would be imprudent to use either scopolamin, morphine or one of the barbituric acid derivatives in a case of contracted pelvis, uterine intertia or placenta previa.

During the past twenty-three years I have tried practically every drug recommended for the alleviation of pain in labor. Like other physicians I have discarded one technic after another for a new one. While I have had no experience with Dial, am using sodium amytal by the mouth, almost routinely. Have used with satisfaction Gwathmey's synergestic analgesia. Its unhandy technic has caused me to forego it for sodium amytal.

I have heard some physicians state that they opposed the use of drugs for the amelioration of labor pains because they prolong the first stage. My answer is this—by saving the patient's strength and nerves in the first stage, you will greatly shorten the second stage, and reduce the patient's chances for infection and hemorrhage. A shorter second stage of labor leaves the patient in a much better condition to combat the complications of the third stage.

Dr. C. R. Marney, Tampa:

I want to agree with everything Dr. Nelson has said. I have probably had as many cases as he has. I used sodium amytal three or four years ago, before it was on the market, got some from Lilly's Laboratory.

I have used Dial, but I use 50% more ordinarily

than he does. I first used Dial by treating a case of convulsions, or eclampsia of pregnancy. I had been using sodium amytal to ease convulsions in eclampsia, but was out of it at the time, and used Dial instead and found it worked very nicely. So I commenced to use it the other way. Dr. Haskell of the Research Laboratory of Ciba & Co., of New York, very kindly sent me about two hundred ampoules gratis, ordinarily retailing at thirty cents per ampoule, which I appreciated very much. Dial is put up in ampoules of 1½ and 3 grains each. It is perfectly safe. You can use grain for grain of it as much as you do with sodium amytal. You can use up to twelve or fourteen grains. The patient will go to sleep with no alarming change or phenomenon. In any observation you make, you will find nothing except maybe a slight lowering of blood pressure. But this low blood pressure, about 10 points, in my observation, soon returns to normal.

One thing Dr. Nelson did not mention: I think it is in order. That is that it seems to me in the cases I have had that the dilatation of the cervix is accelerated greatly. He spoke of the relaxation of the perineum, but the cervix dilates, it seems to me, very quickly. I have used it when I found the patient, a primipara, with dilatation as big as a dime, and delivered that patient in less than one hour. In some cases it does not work so well, but you usually can find some reason why it is slow.

I like Dial very much and I am going to continue using it. However, there is one point that must be stressed. The use of morphine with Dial has not proved very satisfactory to me. In fact, the use of morphine in any case of obstetrics within one or two hours before delivery usually means some cyanosis in the baby. That is my experience. With Dial it is unnecessary.

Care should be taken not to go into the subcutaneous tissue, because it will cause not only irritation, but also a slough. You can give it intramuscularly more easily and with no trouble if you want to use it that way. In fat patients it is hard to get from six to ten grains into the vein. As to dosage: You can go even higher than 2 cc. or 3 grains, even 6 to 8 cc. or 9 to 12 grains, with perfect safety, but you do not ordinarily need that. The highest I have ever used at any one time was 14 grains in two doses, and that was in a woman whom I thought was going to be unruly at the delivery.

You can do an episiotomy on these patients and they will hardly ever move. Under ether, unless deeply anesthetized, they will move very quickly sometimes.

I like Dial very much. You can use it up to 12 or 15 grains in single doses in controlling convulsions or eclampsia. Also, it is almost a specific for cocain or novocain poisoning. I have used it frequently. Sometime when some of you E. E. N. & T. men are going to use a good deal of novocain or cocain give an injection of Dial prior to the use of it. Dial should not be given intravenously more than 1 cc. of the solution per minute, faster may cause respiratory disturbances. The same is true of sodium amytal.

Dr. T. S. Field, Jacksonville:

I have used a good many of these things to alleviate labor pains, as we are all forced to do sometimes. I used Dial four or five years ago by mouth, but never intravenously. But, I want to say that I have seen no one thing that will be universally successful in every case.

One thing I do want to impress on you: When you are using some barbituric acid derivative, you had better have a nurse with the patient about twelve hours after labor, or some of them will get up and step out the window or go out in the hall without ever being conscious of it. Have somebody sit with the patient when you use any such derivative.

About everything you use will slow up the first stage of labor in my experience. I think the dilatation of the cervix mentioned by Dr. Marney was an accident. I have seen a primipara dilate in two hours with nothing administered. Everything that I have ever given to a patient has slowed up labor.

But I am now using some form of barbituric acid in combination with Gwathmey and find it is valuable: in one case you will get a beautiful result, in the next one a fair result, and in the next one no result. But for the average you do get an amelioration of labor pains and the patients are very well satisfied.

Dr. Robert G. Nelson, Tampa (concluding):

I feel that Dr. Norris is quite right in saying that one hundred and ten cases is not a sufficient number by which to judge any treatment. I think he is entirely right, but I have had such satisfactory results with it, that I was prompted to bring it to your attention. I do think that in my experience it has been a wonderful drug. I don't mean to say to you gentlemen that the last

word has been written, at all. I think that a new era is dawning for the amelioration of labor pains.

I disagree with Dr. Field in that he says that everything that he has used has slowed up labor. It has not been my experience that Dial has slowed up labor. It has definitely shortened the length of labor in my entire series. I believe that is due to the fact that the force of the labor pain is increased and the patient is not pulling away or restless from pain.

I have come to the conclusion that opiates have no place in obstetrics. I think if a man is fair enough and will think and look clear enough, if he has done a great deal of obstetrics, he will admit that there has been a great number of babies sacrificed through the use of morphine or other opiate derivatives.

I want to thank Dr. Marney for his remarks Perhaps he has used Dial more often than I have. We have quite frequent consultations on it and talk about it, and our results have been universally satisfactory.

I hope that I have brought a message that really will be worth something to you gentlemen, and that it will prove as valuable to you as it has to me.

CHRONIC INFECTIOUS ARTHRITIS*

Etiology and Practical Methods of Treatment.

Julian E. Gammon, M. D.,
Jacksonville.

The problem of arthritis is one of the unsolved riddles of medicine. In recent years, however, there has been a more concerted effort on the part of the profession in making a scientific study of the problem commensurate with its importance as a cause of human suffering and economic loss. The effort is beginning to bear fruit and some of the phases of arthritis are becoming clarified. The subject arthritis has many ramifications and details which must be omitted in a short paper of this kind.

First of all, I want to focus your attention on the etiological factors of arthritis. There are five important factors each represented by a distinct type of arthritis and I want to show later that one or more of these factors play an important role in the disease. The etiological factors are, namely: first, metabolic dysfunction, for example, gouty arthritis, due to disturbance in purine metabolism. Osteo-arthritis, frequently called hypertrophic arthritis deformans, which has its incipiency in middle age and increasing with age probably belongs to the metabolic group, augmented by the effects of trauma. Second, neuropathic disturbances which are best illustrated by Charcot's joint in locomotor ataxia. Third, trauma, particularly found in clerks who stand on their feet long hours on a concrete floor continually traumatizing their knees. Trauma, however, plays a greater secondary than primary role as a cause of arthritis. Fourth, allergy or hypersensitiveness of the joints to a foreign protein as horse serum and bacterial toxins. All of you are familiar with the arthritis occurring after injection of tetanus antitoxin and, too, in tuberculosis there is an allergic arthritis known as Poncet's arthritis in which the tuberculous patient has acute arthritis and the joint tissues show neither tubercle bacilli nor the characteristic lesion of tuberculosis. There is a good deal of evidence indicating that the arthritis in rheumatic fever is allergic. The primary focus of bacterial infection liberating the antigen is most frequently in the tonsils. Rheumatic fever is a definite type of infectious arthritis which does not leave a deformed joint although deformity of the heart valves and permanent damage to the heart muscle are common. The lack of permanent joint deformity supports the allergic theory. Lastly, we come to the fifth and largest factor as a cause of arthritis, bacterial infection, and we recognize a large list, each type named according to the particular infection, viz.: gonorrheal arthritis, tuberculous arthritis, syphilitic arthritis, septic arthritis, rheumatic fever, dysentery arthritis, scarlet fever arthritis, typhoid arthritis, chronic infectious arthritis of the streptococcus variety, etc.

Throughout the remainder of this paper I am going to discuss chronic infectious arthritis of the streptococcus variety (synonyms:—rheumatoid arthritis, atrophic arthritis deformans). From the evidence in hand chronic infectious arthritis is due most frequently to streptococcus viridans, hemolytic and non-hemolytic. The portals of entry of these organisms are through foci of infection in the teeth, tonsils, sinuses, bronchi, gallbladder, intestines and genito-urinary tract, the teeth and tonsils being the most frequent points of focal infection. Streptococci can be grown in pure culture from these foci, frequently from the lymph glands, occasionally from the blood stream and less frequently from the joint fluids and joint tissue.

It is very probable that in many cases of chronic infectious arthritis the joints are made hyper-

*Read before the 59th Annual Meeting of the Florida Medical Assn., Sarasota, May 3, 4, 1932.

sensitive, as in rheumatic fever, by the primary focus which liberates the toxin or antigen, the arthritis being the allergic reaction. In my experience, this is particularly true in dental focal infection associated with arthritis, as on frequent occasions removal of the focus cures the arthritis and cultures made from the focus most frequently grow streptococcus viridans, the joint fluid cultures being repeatedly sterile. In other cases, however, the joints bear the brunt of the infection, many of the vessels become thrombosed and obliterated, thus materially cutting down the blood supply to the joint structures, the metabolism of the joint being greatly handicapped and altered. From the synovial capsule fringes and villous formations appear and the capsule becomes distended with fluid. Erosion of the cartilage and atrophy of the bone take place and the joint practically becomes destroyed. Nature makes an effort to repair the damage and in some joints we see hypertrophy and atrophy. In joints of this type trauma becomes a factor in its destruction, subluxation frequently taking place.

The clinical course of the disease may be mild with several recurring minor attacks or the disease may begin as a severe infectious disease with irregular fever, rapid anemia, drenching sweats and all the cardinal sins and symptoms or inflammation of the joints, particularly of the extremities; and the muscles about the joints frequently atrophy as though they had lost their enervation. The clinical picture is too vivid to you to justify further discussion.

The diagnosis having been made on accurate clinical, X-ray and laboratory data the next vital question is: what can we do for the patient or against his disease? Since we admit the patient has an infectious disease we may ask ourselves: how does a patient get well of any infection or infectious disease? Briefly answered:

First, by the process of an acquired immunity as in typhoid fever.

Second, by receiving early in the course of the disease sufficient specific immune sera to destroy the invading organism and neutralize its toxin, for example diphtheria antitoxin in diphtheria.

Third, by specific drugs as quinine for malaria.

Fourth, by supportive treatment which relieves symptoms and enables the patient to live long enough to develop increased resistance or immunity, as in the modern treatment of tuberculosis.

Fifth, by surgical extirpation of diseased tissue, and drainage of pus.

From the ups and downs, mostly downs, in the clinical course of the disease it is evident the

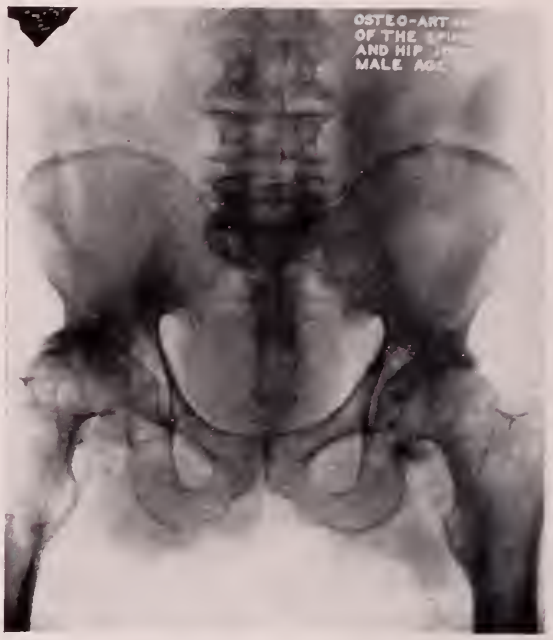


Fig. 1. Osteo-arthritis of the spine and hip joints; male, age 70.



Fig. 2. Spina bifida, club foot, Charcot's joint.



Fig. 3. Syphilitic arthritis.



Fig. 4. Chronic infectious arthritis of the hands and wrist joints.



Fig. 5. Chronic infectious arthritis of feet.

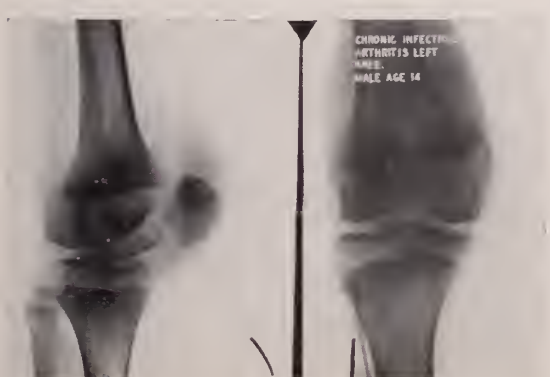


Fig. 6. Chronic infectious arthritis left knee; male, age 14.

patient is not quite able to acquire an immunity, neither have we any specific immune sera or specific drugs to destroy the invading organisms and toxins. Since the cause is most frequently a primary focus of infection, we should search carefully for it, remove it and make cultures for autogenous vaccine which may be used in aiding the patient to produce an immunity or change his joints from a hypersensitive (allergic) to an immune (anergic) state. If the primary focus is not removed early, it may result in multiple foci in the lymph glands, in the joint tissue, and the organisms may be found in the blood stream and we may be too late to be of service.

Autogenous vaccines give the best results in the low grade chronic types and may be given intradermally, intramuscularly or intravenously. The latter method produces the greater immunity providing the patient is not too sensitive to the vaccine. Hypersensitiveness to the vaccine should be tested intradermally before giving small doses intravenously else you may experience severe therapeutic shock.

Vaccines are of little value in patients overwhelmed with bacterial infection, and the results are also disappointing in patients who have extensive joint destruction. Extensive joint destruction can not be cured by vaccine any more than a chronically infected gall-bladder can be cured by vaccine. Vaccine treatment may, however, increase the general resistance of the patient against the infection so that surgical removal of diseased tissue may be undertaken with the least risk as in synovectomy for instance.

The supportive treatment of the infectious arthritic patient is of very great importance and is along the same general lines as the treatment used in pulmonary tuberculosis with the exception of special features. The objective is to build up the general body resistance and relieve special symptoms as they occur. The general outline of the treatment is rest, relaxation, sunbaths, forced feeding with a well-balanced diet and improved general hygienic conditions. Special attention should be given the anemia which is best treated by a well-balanced diet, iron, arsenic, liver, and in some cases transfusions. Pain which in many cases is a troublesome symptom may be relieved by heat, sunshine and various drugs, particularly aspirin, salicylates and soda. In some selected advanced cases sympathetic ganglionectomy and trunk resection have been done for relief of pain. Muscle spasm which soon flexes the extremity in an awkward position is relieved to a great extent by heat and sunshine. The joints usually should

not be put in casts but the extremity should be kept in the best possible position for usefulness should ankylosis occur. By relieving the pain and muscle spasm with heat and sunshine a certain amount of motion will be permitted and the joint is less likely to become ankylosed. Great care should be exercised in preventing the joint from becoming traumatized as you know trauma plays a large part in the destruction of the joint, particularly the weight-bearing joints.

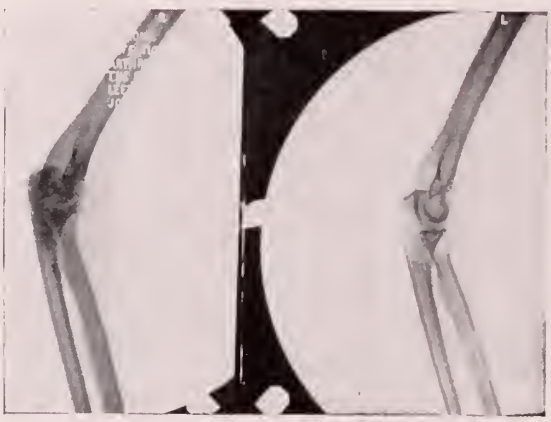


Fig. 7. Chronic infectious arthritis of elbow joint.

In recent years the orthopedic surgeon has come to our assistance, and in selected cases the surgeon has been able to remove diseased tissue, particularly the synovial capsule which frequently stays distended with fluid thus weakening the joint and allowing it to become traumatized. Plastic operations have been done to increase the motion of the joints and other operations have been done to produce ankylosis in weight-bearing joints.

In conclusion, the best evidence we have indicates that there is a type of arthritis which is due to streptococci, particularly streptococcus viridans. The portals of entry of this infection are through foci of infection. Patients complaining of arthritic symptoms should have a careful investigation early, foci of infection removed and autogenous vaccine made thereform and used in desensitizing the joints or producing immunity in the joints before the destruction of the joint tissue is so great that it is incapable of acquiring immunity or repairing its damage.

DISCUSSION

Dr. F. L. Fort, Jacksonville:

Few diseases are worse handled than infectious arthritis. Preventable deformities are allowed to occur, and unnecessary disability and pain are suffered because of our ignorance. With a better knowledge of joint physiology and body mechanics and more effort on our part, the severity and duration of arthritis can be materially decreased.

Along with removal of all possible foci of infection (not afterwards) the cardinal principles of rest and prevention of deformity should be instituted as early as possible. It seems to be a common opinion in the profession that moving an inflamed joint will preserve motion. This is not true. It is the inflammation that destroys a joint, and not lack of movement. Therefore our attention should be centered on eliminating or quieting down the inflammation. We all know that an inflamed eye, or lung or stomach heals better with rest. And yet we cling to the idea that an inflamed joint should be constantly moved. Motion breaks down nature's barriers, spreads the infection and adds insult to injury—if done while there is active inflammation present. Motion should be instituted when the inflammation is quiescent or when there is no local elevation of temperature.

Rest and prevention of deformity can both be secured by application of proper splints. The foot should be supported at a right angle to the body to prevent drop-foot. The knee should be extended or in slight flexion, and the thigh in full extension without rotation. If no mechanical splints are available a plaster cast can be applied and then bivalved, using the posterior half as a splint. In the upper extremity the shoulder joint should be immobilized with the arm in a horizontal position and the elbow flexed to a right angle. The forearm should be supinated and the wrist dorsiflexed or cocked up. The fingers should be semiflexed.

After the acute inflammation has subsided, very gentle massage and active motion should be instituted. Radiant heat from any or all sources lessens the pain and increases the decreased blood supply and is therefore indicated. Massage of the entire affected limb also helps maintain the blood supply and prevents adhesions and atrophy of all the soft tissues. Exercises in water heated to 99 degrees is easier and less painful, since gravity and friction are thus reduced to a minimum. Exposure of the nude body to the direct rays of the sun is of the greatest value in chronic infectious arthritis. The patient's resistance is raised and his whole body metabolism increased. The joint pain and stiffness are decreased by proper sunbaths. The only reason

Florida has so much less arthritis than the states north of us is because of our much vaunted sunshine.

The operative treatment in chronic infectious arthritis is directed toward restoration of function or repair of damage done, rather than curative. Occasionally after the original foci have been cleared up, one or more joints with deep-seated infection persist as secondary foci. The synovial membrane is hypertrophied or thickened sometimes as much as ¼ to ½ inch. Where one or two joints are thus involved a partial or complete removal of the diseased synovial membrane gives excellent results. There is no harm in removing the synovial membrane. It promptly regenerates since it is only modified fibrous tissue anyway.

Manipulations under anesthesia to correct deformity are dangerous, and on the whole to be condemned. Non-elastic tissues are torn and the joint surfaces traumatized or crushed; while the latent infection may be lighted up. There is danger of fracturing atrophic bones, not to mention the danger of thrombosis and fat emboli. Deformities that can safely be corrected by manipulation can usually be corrected better by means of traction or wedge casts. Finger and wrist deformities are best treated by elastic bands attached to the fingers with adhesive and then to a banjo splint. Traction separates the joint surfaces, stretches the joint capsule and permits of more motion with less pain than can be obtained otherwise. Occasionally it is necessary to cut firmly contracted joint capsules to correct deformity. Contracted tendons in old cases may be lengthened quicker with less suffering by operation than by less conservative methods. Removal of bone spurs or osteophytes from the joint margins, when causing pain, is indicated, after the arthritis has entirely subsided. Hopelessly rough and painful joints can be ankylosed to advantage in selected cases. Arthroplasty on ankylosed joints, while not very successful in the lower extremity, is very useful in the elbow and temporo-mandibular joints.

Dr. Clayton E. Royce, Jacksonville:

The opening sentence of the essayist's paper where he stated that arthritis is one of the unsolved riddles of medicine, strikes me very forcibly. It is a challenge to the profession as a whole. And I might add that the wide range of etiologic factors, direct and indirect, which may operate separately or in combination, is apt to lead to fanaticism in treatment. It is necessary to consider all of the factors touching the treatment of the individual case.

The name "streptococcus viridans" I think is very well chosen. A recent report of 801 cases investigated showed blood cultures to be positive in 279 of these cases with streptococcus, and almost all of them streptococcus viridans, although a few were streptococcus hemolyticus. Of 218 joint blood cultures made on these cases, 76 were positive, a pretty low percentage, comparatively. But in the joint tissues, of 32 cultures made, 14 were positive, nearly 50%.

As to determining the specificity of the organism obtained from the cultures, the means most usually followed is the intradermal injection of a very small amount of the suspension of the organism. The results of this investigation are not entirely indicative that we have a specific organism even where we believe it to be so. Out of 127 arthritics injected with cultures of organisms isolated from their foci, 112 responded positive; but of 107 non-arthritics injected with organisms from these other arthritics, 53 responded positive.

Recently I heard a paper by Dr. Kofoid of California, in which he stated that he had found amebae or amebiasis in joint tissues where no other form of infection was demonstrable. This author was quite confident in the value of the search for amebiasis in all sorts of cases which defied other means of diagnosis.

While admitting the predominance of the infection factor, it must not blind us to the numerous cooperative factors. Most of the study or treatment directed toward colon diseases, changes in function, character, etc., has resulted in an improvement of the intestinal and joint conditions.

In a recent report Dixon stated that vitamin B defect produced in experimental animals a redundancy of the colon, precisely the condition most commonly observed in the colons of arthritics. Restoration of vitamin B to the diet of these animals restored the colon to the form seen before the withdrawal of the vitamin. This may point the way to the prevention of arthritis. In any event the evidence now at hand indicates that the gastro-intestinal tract of arthritics should be studied by X-ray as a basis for therapeutics.

In selected cases it has recently been shown that low calorie and vitamin-free diets produce quickly, relief from pain in both atrophic and hypertrophic non-infective metabolic joints. This

form of treatment might take its place in that class known as supportive treatment. This same author believes that intestinal deformity and dysfunction precipitate arthritis, and that in cases not relieved by elimination of infection the vitamin defect is the original inciting factor in the production of this disease. Improvement in arthritis follows dietary adjustment. This should stimulate our interest in using and advocating a balanced diet. Enteroptotics tend to become arthritics. This opens a means for preventive work among school children.

I wish to congratulate the essayist for the success with which he has in this short paper set forth the salient factors of so broad a subject.

My observation confirms what he has said regarding streptococcus viridans in arthritis. Because of this, I have with more pleasure reviewed some of the aspects of this very far-reaching problem.

Dr. C. D. Christ, Orlando:

Dr. Gammon exhibited two pictures of the large bowel. Both of these pictures showed a diverticulitis. I have done quite a little X-ray on these arthritic cases, and practically every one in the advanced stage had a defective colon. They have diverticuli, large pockets, frequently of the hepatic flexure, and a lots of times the transverse colon is hanging down in the pelvis and very much dilated. Now, if these conditions can be corrected by the control of vitamin B as has just been suggested, or if they could be recognized early, in all probability our problem of these devastating diseases could be made a great deal better. But, when a colon gets into the condition the doctor has shown here there is no medical or mechanical treatment that is going to avail.

At the State Hospital in Trenton, N. J., Dr. Cotton and Dr. Draper did a lot of work on the insane. Their first idea was a complete removal of the colon. Their mortality rate was exceedingly high, running from 17½% to 45%. They later attempted to plicate and did plicate these diverticuli, and they got some pretty good results from that work. However, they later short-circuited the colon, simply cutting off the terminal ileum eight or ten inches from its entrance into the cecum, purse string both ends, and anastomosing the proximal end of the ileum to the sigmoid flexion.

I have picked out three bad cases, two of arthritis and one of a soldier paralyzed from a broken back, and operated on them. The first one, I made the fatal error of doing a lateral anastomosis, and let my patient get well intending to go back in six weeks and cut off the gut. The patient got so well she gained 20 lbs. in weight in a period of nine weeks, her arthritis cleared up, and it was a most miraculous result. However, she refused to let me do the second stage of the operation. I saw her up to the fifth month after operation and she laughed at me for wanting to finish the operation, since she was so well. But, at the 11th month I was called to see her, and she was in a moribund state, had lost everything. Now, I fully believe had I done that operation in a one-stage operation she would have been alive and well today.

The other two are living. The arthritic case is quite well, although it was in a rather advanced stage. He has gotten a lot of function back that he did not have at the time of the operation. The soldier, whom I operated upon strictly for three enormous diverticuli or distentions of the colon is quite well. His bowels had not moved in 14 years without from four to six quarts of water, and now they are moving every day with an aid of some simple aperient. He has only about eight inches of bowel down there in which apparently he has no function, whereas formerly he had nine feet of bowel in which he had no function.

I don't want you to go home and operate every case you see, but I believe that if you gentlemen will select your cases, and in cases particularly like Dr. Gammon has shown here, apply a short circuit to the colon by a lateral anastomosis of the terminal ileum to the curve of the sigmoid, you will probably see some results. In the more advanced cases I don't know whether it will do their joint conditions any good, but in the less advanced cases, I believe it will do them a great deal of good.

CHRONIC ARTHRITIS*

Leland F. Carlton, M.D., F.A.C.S.,
Tampa.

Chronic arthritis in the past few years has attracted more attention from the medical profession than during all the centuries preceding. It is the one disease which should attract the interest of the entire profession, from the internist to the orthopedic surgeon. Cancer with all its ravage, to the public mind, is the most horrible disease known; but did you ever stop to think that chronic

*Read before the 13th Annual Meeting of the Florida Railway Surgeons' Assn., Sarasota, May 2, 1932.

arthritis is taking its toll from the laboring class with equal percentage of disability? Cancer has its advantage in that it takes the life of the individual with a rather short period of disability. Chronic arthritis produces a permanent disability, with the patient a care upon the public and without taking the life of the individual.

It is not within the scope of this paper to discuss acute arthritis as rheumatoid arthritis, etc., but rather the more disabling chronic forms which may come under two classes, viz., atrophic and hypertrophic arthritis.

Atrophic arthritis manifests itself upon the individual at or before middle life, whereas hypertrophic arthritis is a disease of old age.

Heredity is said to be an important factor in 50% of all cases of chronic arthritis. Not that the case is directly inherited but the underlying individual characteristics predispose to the development of the disease. This predisposition is not limited to the mechanical construction of the bony skeleton alone but may be due to other conditions of posture such as gall-bladder and intestinal tract deviation.

The definite exciting cause in all arthritis has not yet been found. It is a known factor that certain bacteria have an affinity for certain body tissues, viz., typhoid bacteria affect chiefly the lymphoid tissue of the lower ilium; the pneumococcus, the lung; diphtheria, the throat; meningococcus, the meningis, etc. Rosenow in his experiments has demonstrated that the organism which is the chief offender in arthritis is the non-hemolytic streptococcus. Haden following the recommendation of Rosenow injected bacteria from chronic foci, such as the eye, kidney and peptic ulcer and was able to produce arthritis in animals similar to that coming from chronic focal infection in man.

Both types of arthritis are systemic in nature with localized manifestations of bone and joint changes. There may be, however, patients with the arthritic syndrome, who do not demonstrate these characteristic bone and joint changes.

Atrophic arthritis or, as classed by some, proliferative arthritis of uncertain origin, is the most disabling form with which we come in contact. It was described by Osler as "one of the most terrible of human afflictions." There may be two clinical types of atrophic arthritis. The one with sudden onset of fever, pain, etc., and involvement of many joints; the other, slow in onset, with remissions of symptoms and with each succeeding exacerbation, other joints become involved. In both types flexion deformity develops with ankylosis the final stage. The ratio of sex occurrence is 3 females to 1 male. Exposure to cold, influenza and focal infection may play an important part and frequently there may not be any history of anticedent disease or injury.

The other type of arthritis is somewhat a natural sequence of advancing years. It has been called by various names, all of which mean the same, viz., arthritis deformans, osteo arthritis, degenerative arthritis, heberdens nodes, morbus coxae seniles, and hypertrophic arthritis.

This type of arthritis may involve one or more joints; moderate pain; the joint is swollen and thickened. Marked deformity and ankylosis rarely ever occur. It is the oldest form of arthritis of which we have medical record.

Its etiology has never yet been proven. It may be due to continuous wear and tear on the joint or to trauma, or both. Infection may play a part, but this has never been wholly accepted.

A pathological study of the beginning changes of chronic arthritis has not been extensively done because one does not have the opportunity of exploring joints of this type until after destruction is done. In atrophic arthritis the cartilage is destroyed by a granulation growth from beneath the cartilage with a synovial panus from above. This leads to adhesions and later ankylosis of the joint.

The other form, hypertrophic arthritis, is characterized by a degeneration of the joint cartilage, thus leaving the bone bare and exposed, with bony proliferation at the joint margin commonly known as lipping. These proliferations may become separated from their base by trauma and produce loose bodies in the joint, known as joint mice, which may become disabling and demand removal.

The X-ray differentiation is usually easy. The classical picture in atrophic arthritis is marked by atrophy of bone, with narrowing of joint space and frequently evidence of ankylosis, whereas in the hypertrophic arthritis there is increased density of the bone with marginal irregular proliferations.

In many diseases the diagnosis is hard, but after diagnosis is once made, the treatment is easy. Chronic arthritis is quite the reverse. Diagnosis is easy but treatment is unsatisfactory in many instances. Each individual case is a

study within itself. One must take into consideration the hereditary tendency, general posture (bony skeleton and viscera), habits, occupation, diet and mode of living. The one who depends on any one method of treatment for arthritis will soon find it unsatisfactory and see his patient go from bad to worse.

Drug treatment alone is of little value except in the control of pain and probably causing vasodilation of the arterioles of the extremities and also as an aid to general physical improvement. Sympathetic ganglionectomy as advocated by Mayo's has recently been used in a selected group with a great deal of advantage in increasing the blood supply and raising the temperature in the extremity involved. Diet, rest, localized heat, fresh air and general correction and prevention of posture deformity, with a removal of all infected foci, is the general outline of treatment.

THE TREATMENT OF MEDICAL CASES AT HOPE HAVEN*

THOMAS M. PALMER, M.D.,
Jacksonville.

From the standpoint of the medical service, Hope Haven functions as follows: (1) as a preventorium; (2) as a haven for those woefully undernourished but not infected with tuberculosis; (3) as a convalescent home.

At this point, I feel that you should have a very clear understanding of the following: (1) that the contagious or adult form of tuberculosis (which by no means is limited to adults but which may occur even in infants) is not admitted to Hope Haven; (2) that children are not sent to Hope Haven in order that tuberculous infection may not take place. On the contrary, we select for admission those children who have been infected; who, in addition, show, by X-ray films of the lungs, the changes typical of childhood tuberculosis and who show symptoms indicating an active process. Just how varied these signs or symptoms may be we shall point out later.

You should also have a very clear understanding of the terms "Adult Type of Tuberculosis" and "Childhood Type." The adult type of tuberculosis is characterized by actual destruction of lung tissue with, in the majority of instances, the appearance of the tuberculosis germ in the sputum and body discharges. This type is, therefore, considered contagious. The childhood type, on the other hand, is characterized by the enlargement of glands beneath the breast bone. As far as we know, no tuberculosis germs are ever recoverable in the sputum or body discharges and, therefore, this type is not contagious.

As a preventorium and, in spite of its limited number of beds as well as limited finances, Hope Haven is a veritable God-send to this community for it is the one great weapon by the means of which we have hope of preventing the further development of tuberculosis in that class which we always have with us, the poor. The poor, as you are well aware, are unable to properly care for their children at home even during the best of times because they are often ignorant.

Not many years back we waited for the development of a definite train of symptoms before making the diagnosis of tuberculosis. In other words tuberculosis then meant active, advancing tuberculosis with actual destruction of lung substance. Now (and this is the whole idea we have in mind when we perform the tuberculin test on a wholesale scale such as was done only recently in certain schools and orphanages in this city) we attempt to diagnose the disease in its earliest stages, the childhood type, and we proceed (or should proceed) in such a manner as to prevent the further development of the disease. In short, by being forewarned (knowing that childhood tuberculosis is present in a given child even though there have never been symptoms to indicate its presence) we are forearmed, we are able to institute preventive measures at the proper time.

In our work of prevention it will, perhaps, be of interest to you to know just how we proceed. As far as the medical service is concerned, Hope Haven receives its patients from two sources namely: (1) those admitted from the Duval County Hospital by way of the children's clinic and (2) those admitted from the physicians' offices. The former group comprise, by far, the greater number of admissions. In both of these groups a complete history is taken. This history in the majority of cases gives us no inkling of contact with tuberculosis nor is there anything definitely suggestive of tuberculosis. A very careful physical examination is followed, in each and every instance, by a routine tuberculin test which test is performed exactly like the Schick test. Three days later, the patient returns for

*Read before the Annual Joint Meeting of Hope Haven Assn., Inc., and Tuberculosis Assn. of Duval County, Inc., Jacksonville, June 6, 1932.

the reading of the test. In the event that the test is positive an X-ray of the chest is made. This X-ray is absolutely essential, the absolute diagnosis of tuberculosis resting upon its proper interpretation, for we know, of course, that many children show a positive tuberculin but no X-ray signs of the disease. These children have simply been infected at some time and have taken care of the infection. By employing this routine there is very little chance of a case of childhood tuberculosis escaping our notice.

In defense of this routine, though chiefly in order to appease those few with an economy-complex and who may feel that we are in a fair way toward bankrupting Duval County, I hasten to add that there are, in reality, few positive tuberculins and therefore not the enormous number of X-rays required such as one might imagine.

From the experience gleaned in such a clinic we have found that the time-honored symptoms, formerly considered necessary for the diagnosis of tuberculosis, namely, loss of weight, profuse night sweats, cough, elevation of temperature, are not the symptoms commonly presented. On the contrary, childhood tuberculosis appears to the physician as (1) the hardly sick child, (2) the lackadaisical child, (3) the transitorily upset child or (4) the overritable child.[1] Furthermore, it is of the greatest significance that average weight, yes, even overweight, does not preclude the possibility of the childhood type of tuberculosis.

In general, how often do we encounter these cases of childhood tuberculosis and what does fate hold in store for them? From the findings of the ten-year program of the State of Massachusetts[2] we have the very interesting information: (1) that the lesions of childhood tuberculosis are found in 2 out of every 100 school children; that as a group these children are twice as prone to develop the adult type of tuberculosis as are the members of that group who have simply been infected, i. e., who possess only a positive tuberculin but no X-ray evidence of disease; (2) that 1 in every 1,000 school children have the adult type of tuberculosis; one boy for every three girls. The average age of occurrence was 13.4 years. About 5 years later 24% of the boys and girls in this group died, the girls showing twice the mortality of the boys. Added to this is the most discouraging fact that the majority of those still living show signs of steadily progressing disease. Now you see why we are so anxious to diagnose tuberculosis in its very earliest stages.

We know that in more than 50% of the cases of active tuberculosis in young adults there has been a preceding tuberculous infection during infancy and childhood. It is a sad fact, though only too true, that in the majority of instances this infection has been entirely unrecognized by both parent and physician. Such a state of affairs cannot exist if we employ our two great allies: the tuberculin test and the X-ray.

Dr. Allen Krause[3] has very aptly and beautifully said: "That the child is father to the man is never truer than in the domain of human tuberculosis. Seeds strike root in childhood; roots take firm or weak hold as the immature body wrestles with the stresses of growth and development poorly or well; pulmonary tuberculosis, bane of cooped up civilization, bursts, as life's powers unfold, to the full with the coming of adult years. This is the story of the common run of tuberculous patients. They reap what indifferent circumstance has sown in them in long-forgotten, by-gone years. Touched by tubercle bacilli they are the unlucky heirs of accident and ignorance, of which ignorance is, perhaps, the more prolific breeder." In this connection and, as an example of ignorance, I simply mention the fact that only a short while back a thoroughly intelligent mother told me that the first intimation of tuberculosis in her 9-year-old daughter was a frank hemorrhage from the lung. Then of course an X-ray was made and the adult type of tuberculosis was quite apparent. Not only this but tuberculosis germs were recovered from her sputum. This is exactly what we are trying to prevent by employing our diagnostic aids, the tuberculin test and the X-ray, early in life.

In our preventorium work at Hope Haven there are two chief modes of attack.

Firstly, we admit only those children with childhood tuberculosis who, in addition, are substandard in health. By the term, substandard in health, we do not refer solely to undernutrition but we consider unwonted pallor on a par with cough; premature heart beats, depressed blood pressure, overirritable heart on a par with elevation of temperature; and nervous irritability and headache on a par with under nutrition.[4] All of these symptoms are indicative of active childhood tuberculosis and they make treatment imperative.

Secondly, by admission to Hope Haven we break contact with the source of infection which is, as a rule, some adult member of the family. We know only too well that an active case of pulmonary tuberculosis in a home is the source of greatest danger to children of any age.

Since the number of our beds is limited (Massachusetts, we are told, has 700 beds for the care and education of the above class of children), we cannot, nor is there any reason why (excluding abject poverty) we should, admit those children with childhood tuberculosis who are in no wise substandard in health. These constitute the inactive cases of childhood tuberculosis. These we instruct along the same lines of care as Hope Haven offers; namely, rest, diet, sunshine and the proper regulation of activities, plus the breaking of contact.

When the substandard-in-health children have come up to standard health they are discharged from Hope Haven. These formerly active cases of childhood tuberculosis along with those whose tuberculosis was inactive on first examination, should be subjected to a very careful physical examination every six months. Preferably, two X-rays a year should be taken; certainly one is the minimum. In this manner, and this alone, are we really able to detect the real course of events; whether the process is remaining in bounds or spreading.

The two weak points in our prevention work in Jacksonville are, firstly, our woefully inadequate number of beds and, secondly, our woefully inadequate funds for providing even the minimum number of X-rays both for purposes of diagnosis and follow up work.

Occasionally, we feel fully justified in admitting to Hope Haven a child who has been afflicted with a very prolonged illness, such as a pneumonia which has developed pus in the chest requiring weeks or even months of treatment in the hospital. When the home conditions are hopeless we feel that they should be given the benefit of a month or two in the country.

A third type of patient whom we admit is the extremely malnourished type. As a rule, this type of patient responds beautifully to treatment for the child not only is offered real food but, in addition, learns to eat and relish this food. One might well raise the questions: Why cannot these children be taught to eat the proper foods at home? Why waste one of our valuable beds on such a case? The answer is that such a child cannot be taught at home after so many years of improper food habits. It is an impossibility. A second reason for admitting these children is that all of them have very poor posture which demands immediate correction before deformities of the spine develop. This deformity of the spine usually manifests itself as a curvature, the so-called adolescent curvature, and is due primarily to muscular insufficiency. It is, in fact, a failure of sufficient structural development of the muscles of the back which, in turn, is often traceable to lack of fresh air, sunshine, proper food and physical exercise[3]. In Florida we are not confronted with the lack of fresh air and sunshine but we are seriously confronted, at this particular time, with the very great lack of proper food in spite of the fact that the cost of food has declined so greatly. Hence, we can do a very great deal toward preventing this adolescent scoliosis from becoming a fixed curvature by the proper feeding of these children as well as the institution of certain exercises for their daily performance. Many of these children are, in addition, anemic and this we can readily correct.

After these patients are discharged from Hope Haven, they should undergo periodic health examinations just as we advocate in the group with childhood tuberculosis. Also, we should never neglect the periodic parental interview in order to be certain that our instructions are being properly carried out at home.

In speaking to an organization interested not in the prevention of one disease alone but in the prevention of all diseases, it can hardly be considered amiss to mention a problem which is staring us in the face, namely, the problem of preventing rheumatic heart disease. Very shortly after my arrival in this city, I was greatly cheered by the good news that rheumatic fever and rheumatic heart disease were confined very largely to the northern states and could not be considered a problem with us. As far as the white race is concerned, this may be true although every month's contact with the children's Clinic of the Duval County Hospital causes me to doubt more and more the truth of this statement. As far as the colored race is concerned, I have seen just as much, perhaps even more, rheumatic fever in Jacksonville as I saw in Baltimore. Why mention rheumatic fever? We mention this because of its pronounced tendency to damage the heart which damaged heart gives rise to the symptom complex known as rheumatic heart disease. And what of this disease? What are its claims to notoriety? It bears the distinction of

being a killer of the first order as witness the deaths of three children on our ward at the Duval County Hospital during the past five months, all with rheumatic heart disease and not one over 11 years of age.

How can we attempt the prevention of rheumatic heart disease? By providing an adequate number of beds in order that those children with St. Vitus' dance (chorea); with so-called inflammatory rheumatism and with a host of other symptoms (many of them very mild) indicative of rheumatic fever may be given from three to six months of absolute bed rest. By this rest we are protecting a heart which we believe to be invariably damaged during the attack of rheumatic fever and which, if not protected, will, even months later, manifest this damage as rheumatic heart disease.

In conclusion, I should like to compliment most highly the Tuberculosis Association upon the great and growing interest which their workers have stimulated in the tuberculin test. By virtue of their untiring efforts the erstwhile impossible has become possible, as witness the wholesale testing of children only recently carried out in this city. The average lay member will never realize what obstacles have been surmounted for certainly in no other line of preventive work does one encounter more deeply rooted prejudices than in the prevention of tuberculosis. The progress made during the past two years (the period of my acquaintance with the work) has been nothing short of startling. Again I congratulate these workers.

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THE TREATMENT OF THE CRIPPLED CHILD AT HOPE HAVEN*

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Jacksonville.

Hope Haven was created by the Duval County Tuberculosis Association for the purpose of (1) preventing tuberculosis from developing in children and (2) for the treatment of surgical, or bone and joint tuberculosis. Dr. Palmer has told you about pulmonary tuberculosis in children at Hope Haven. It is my task to tell you what we are doing for crippled children, and especially those with tuberculosis in bones and joints.

When I came to Jacksonville eight years ago, I found myself burdened with six or more children, languishing away with tuberculosis of the spine, hips or other joints. The general hospitals took them in grudgingly or refused to take them at all. They knew that these children would be on their hands for months or years, and that the end results would be nothing to boast about. It was quite evident that they could never receive proper care in their homes. Usually tuberculosis develops in homes that are unsanitary, poorly heated and lighted, and where the family is poorly fed. The children are usually poorly managed or, if given proper personal care, they are overindulged. It is a most difficult undertaking to convince a mother that her child has tuberculosis, and that she can and must help the doctor cure it. For three or nine months she may follow instructions to the letter. But after all pain, fever, swelling and other active symptoms have disappeared, she becomes convinced her child is well and that the doctor is an extremist or does not know what he preaches. All human beings err at times, and this includes the medical profession, but I am convinced that the great majority of tubercular patients die because they do not follow their doctors' advice early enough or long enough, or perhaps do not seek his advice at all.

In bone tuberculosis we can usually make the correct diagnosis before life or limb is endangered, if given a chance. Usually we are given this chance of making the diagnosis and often allowed to institute proper treatment. It is the exceptional case of tuberculosis that does not respond to treatment, and soon become quiescent. After the active disease has subsided, we then reach the dangerous convalescent stage when relapses occur and the battle is won or lost. It is the nursing care, rest, and feeding, that count in tuberculosis. The actual medical care by the physician amounts to very little in comparison to the nursing care. So, because of poverty, ignorance, and parental indulgence, it has been found necessary to place these children in special homes, where they will get what they need in the way of rest, food, sunshine, and discipline, which they do not get in their homes. It is most discourag-

*Read before the Annual Joint Meeting of Hope Haven Assn., Inc., and Tuberculosis Assn. of Duval County, Inc., Jacksonville, June 6, 1932.

ing to work six months or longer on a child, until the disease is arrested and you have reason to hope for a cure eventually, only to find some day, the child has been allowed to walk "just a little." The disease has become active again and all of your labors have been in vain. Sometimes it is physically impossible for parents to give their children proper care, even though they are more than willing. Sometimes parents are too ignorant to carry out instructions. It is here that Hope Haven comes to the rescue and makes it possible to correct or prevent deformity and arrest or cure the disease.

We do nothing extraordinary in the way of treatment. We have no new system or fad to promote. Our methods are the same as those in general use in similar institutions throughout this country and other countries. Upon admission to Hope Haven we know that these children get the proper kind and amount of food, and at the proper times. This is a very important thing, and one that we can never feel sure about in home treatment. Friends or grandparents or other children give improper foods at irregular times to the patient in spite of all the mother can do. Hope Haven enforces regular sleeping habits, both night and day. It is surprising how easy it is to train 20 children to actually sleep between 1:00 p.m. and 2:00 p.m. daily. For those allowed out of bed, ample rest periods are prescribed according to their needs. This is also a difficult thing to do in the average home.

All are assured of an abundance of fresh air, day and night. Clothing is very meager both winter and summer. The ordinary "cold," frequently seen in our own children, is seldom seen at Hope Haven, where we have sub-normal children only. We have not had a case of pneumonia develop since the institution was opened. Practically all of our children are given daily sun baths, whether they are bed patients or not. The nude body is gradually exposed to the direct rays of the sun for gradually increasing lengths of time. To me, this is our one greatest asset. Undoubtedly, it is of benefit in building up a sub-normal body almost regardless of the disease with which it has been afflicted.

Besides this general routine care, which they all receive, special treatment is provided for the individual needs of each case. You will note that I have not mentioned drug therapy, because drugs play a very minor role in the treatment scheme at Hope Haven. Practically all receive cod liver oil, which is more of a food than a drug. Braces, casts, and traction apparatus are applied to prevent or correct deformity as well as to enforce rest in the diseased limb. These are gradually discharged as the patient's improved condition warrants it. If any corrective or curative surgery is found necessary they are transferred to one of the local hospitals for the operation and then returned to Hope Haven after a few days.

Soon after Hope Haven was opened, we found that there were not so many cases of bone and joint tuberculosis as we anticipated. After eight years of work in this field, I feel convinced that Florida has not more than one-fourth as many bone and joint tuberculosis cases per capita population as the northern half of our country. Time will not permit consideration of this fact now. It was found necessary to admit other types of crippled children to Hope Haven, who were equally in need of special treatment, which could not be given in our local (general) hospitals or in their homes. We have a large number of bone and joint infections by germs other than the tubercle bacillus. These cases of osteomyelitis do unusually well out there. They receive the general routine care including sunbaths, proper change of sterile dressings, etc., which cannot be secured in their homes. We try to keep them until they are entirely well. We provide convalescent care to a number of crippled children from distant parts of the state who require several months of observation and intermittent treatment for deformities, either congenital or acquired. The state pays Hope Haven for the care of these cases.

There is one other type of disease that Hope Haven is especially suited to handle, and is rendering, in my opinion, a very valuable service to the community. I refer to poliomyelitis or infantile paralysis. It is possible to prevent deformities and secure improvement and even cures in this dreadful disease during the first few months after onset of the paralysis. A routine care is needed, including braces, massages, sunbaths, water baths, etc., that it is not possible to get in the hospital or home. There are few institutions anywhere that can do more for them than Hope Haven. This may sound boastful, but it is certainly true, unless one has unlimited funds. We have infantile paralysis cases every year here in Jacksonville, and I feel sure Hope Haven is the proper place for them.

Hope Haven is still in its infancy, but I am quite sure it has been a real life saver to one or

more children each year of its life. It has saved numbers of others from a lifetime of deformity and disability. As an economic venture, I believe it will return manifold to the state every dollar invested in it. It is one of my greatest ambitions to see it continue to grow in usefulness and in size, so that each of us will look back with pride and a deep satisfaction that we helped to build it.

THE POSSIBLE ADVANTAGE OF THE REMOVAL OF PERSONS SUFFERING FROM RECURRENT RHEUMATIC ENDOCARDITIS TO THE TROPICS

Louis Faugeres Bishop, M.D.,
Louis Faugeres Bishop, Jr., M.D.,
New York.

Geographical distribution has always helped in unraveling the causes of disease, and if it can be shown that rheumatic fever is found in countries outside the tropics and is unknown among the inhabitants of tropical countries the search for the cause of this disease will be greatly narrowed. What we wish to determine is whether, when we are in touch with anyone suffering from endocarditis after recurrent attacks of rheumatism, we can hold out hope for this person that by living in the tropics the progress of the disease can be checked and life prolonged. The course of this disease is so uncertain and the people affected are relatively so few in number, and moreover those who will submit to such a transfer will be so small in number that the experiment will take a long time. Nevertheless, at any time we may be faced with the problem of advising the future life of such an individual; therefore, the value of tropical climates should be known.

A review of the literature seems to make it fairly certain that the type of disease described above rarely originates in the tropics. Whether the influence that prevents the origin of such a condition can also be counted on to check it when once started is what we wish to determine.

Formerly, it was believed that attacks of broken compensation in valvular disease were usually due to strain. Now it is known that infection is really a much more frequent cause.

In this connection it is very important to draw a distinction between rheumatic heart disease and the degenerative type that goes with kidney damage. While rheumatism is said to be almost unknown in the tropics, kidney trouble is very frequent.

Our impression is that failure of the cardiorenal system under the strain of unhygienic living is very frequent in the tropics. Anyone who has experience with in-between climates knows that adequate heating and the fine construction of the buildings in New York City, for instance, tend much less to exposure than the poorly heated and badly constructed buildings in the lower temperate zone. In many parts of the tropics the temperature varies but few degrees the whole year round, while in the lower temperate zone there are often extreme changes in temperature. The tropics should not be confused with Southern France or Northern Africa.

William H. Thompson, who taught therapeutics so many years in New York, often spoke of the extreme changes in temperature that he suffered in the desert of Sahara. This is true of California and many places where tuberculosis is successfully treated. The rheumatic problem and the tuberculosis problem are a very different matter. In this connection J. Tertius Clarke has called attention to the importance of clearly having in mind what we mean when we say "the tropics." One definition of the tropics is the area which lies between 23°-28° North and South. The important difference between the climate of this area and the rest of the world is that the other parts have seasons whereas the climate of the tropics is always hot and except for the difference of rainfall is practically unseasonal.

It is not our purpose here to elaborate on what is meant by rheumatic fever except to say in this study we differentiate rheumatic fever from other forms of rheumatism, such as rheumatoid arthritis.

It has long been recognized that rheumatic fever is more prevalent in the temperate climates than in the hotter parts of the earth, and the greatest incidence is in the autumn of the year when the hot weather is finished. In spite of such statistical evidence, many authors write that rheumatic fever is widespread throughout the world and that climatic conditions do not play such an important part as would appear upon first glance.

J. Tertius Clarke has paid more attention to this subject than almost any other man. He writes: "My own experience of medical work in the tropics extends to thirty-three years, during nearly the whole of which it was not merely that I did not happen to see a case of rheumatic fever but that I looked for and did not find one. My instruction to my subordinates was to call my

attention to any case of enlarged joint or of what they thought was heart disease. During this period I saw about 150,000 in-patients of one kind or another but did not meet with one single case of rheumatic fever, mitral stenosis or chorea. Nor did I find, though I held many post-mortems, any case of a valve suggestive of the scarred valve of a rheumatic heart."

The thought arises, does rheumatic fever occur in a typical form in the tropics so that it might be mistaken for influenza or other febrile conditions.

While Miami is not in the tropics, it is nevertheless, so nearly tropical that perhaps it might be well to include the experience of Dr. E. Sterling Nichol, writing in the Journal of the Florida Medical Association, February, 1931: "In private practice only three cases of rheumatic fever in three thousand patients. In the Jackson Memorial Hospital, Miami, from January, 1925, to July, 1930—five and a half years—there were four true cases of rheumatic fever and six cases of chorea, a total of ten cases; 31,000 patients were admitted. Thus, there was only one case of acute rheumatic fever or chorea to 3,000 admissions to the hospital. None of the cases were negroes." He concludes, "The incidence of rheumatic fever in this climate is extremely low and therefore we should find among children born and raised in this climate practically no heart disease of rheumatic origin."

Many people have thought that in the development of the rheumatic state, infection was of rather minor significance and that the cosmic forces of the environment were of real importance. One of the best studies of the question is found in Coburn's book, "Factor of Infection in the Rheumatic State", January, 1931. To evaluate this influence of environment with sunlight, warmth and other characteristics, a colony of rheumatic patients was established on Porto Rico.

Coburn, p. 118, states that a study was made by Dr. Edward Feeley of "The Influence of Tropical Environment in Rheumatic Disease." In this study, correspondence has been carried on with clinicians and pathologists in a number of countries of both hemispheres. In addition, Dr. Edward Feeley traveled through tropical countries around the world during 1928 and 1929 to determine the presence or absence of rheumatic disease. (The questionnaire below was used by Dr. Feeley and in this correspondence.)

QUESTIONNAIRE

City
Country
Authority
Address.....Hospital.....
Races
Any Rheumatic Fever?
Any Chorea—St. Vitus Dance?
Any Rheumatic Heart Disease?
Any Mitral Stenosis?
Any autopsy findings of Rheumatic Heart Disease, such as Mitral Stenosis?
Season for Rheumatic Fever?
Season for Tonsillitis?
Many bacteriologically proven hemolytic streptococcus infections?
If so, at what season?
Any Asthma?
Any Scarlet Fever?
Any chronic Arthritis?
Any Erysipelas?.....
Climate: Sunny?.....Foggy?.....
Hot?.....Cold?.....
Remarks:

Because of the difficulty in diagnosis and the absence of necropsy material in many parts of the world, accurate data are not available. On the other hand, the material collected "the sources of information are tabulated in the appendix" suggested that in North America the disease is at present prevalent and severe, between latitudes fifty degrees and forty degrees North, not uncommon between forty degrees and thirty degrees North, rare between thirty degrees and twenty degrees North, almost unknown between the Tropics of Cancer and Capricorn, rare between twenty degrees and thirty degrees South, common between thirty degrees and forty degrees South. In the Eastern Hemisphere it seems likely that there is a similar tendency for the disease to manifest itself rarely in the Tropics, to be present in South Africa and Australia, also in Japan and Northern China, but especially prevalent in Northern Europe.

No tropical country was found in which rheumatic disease is common. In Hawaii it was learned that rheumatic heart disease occasionally develops insidiously. Chronic tonsillitis and chronic arthritis were, however, found to be common in many tropical countries; while erysipelas was by no means uncommon. It was considered significant that only in those countries in which scarlet fever manifested itself was there found striking evidence of rheumatic disease. The incidence and severity of scarlatina in many regions appeared comparable to the incidence and severity of rheumatic disease.

Information collected in this way is by no means accurate. However, because of the apparent rarity of rheumatic disease in many

tropical countries, a more thorough investigation was made of the island of Porto Rico. There it was learned that tonsillitis was not uncommon, but that rheumatic disease was rarely seen clinically.

In considering the question of climate we must be very careful to remember that at the present time we have no really true conception of the etiology of rheumatic fever. We also know that the disease differs in character in different parts of the world. For example, the rheumatic nodules which can so often be found during the course of the disease in England are seldom found in this country.

The opposing view of climate in rheumatic fever has been very well upheld by Dr. Charles W. Buckley, who says: "If an organism does not adapt itself to its meteorological environment, it is more susceptible to its parasitic environment. Disturbances due to lack of adaptation to climatic changes can, in part, be offset by altering the diet. The weather and food factors cannot be separated and one can influence the other.

"Changes in climate are beneficial to the well-being of the population living in the temperate zones where meteorological conditions are ever changing as compared to the steady cold in the artic or constant heat of the tropics. . . .

"It seems to be an advantage to an organism to be in a changing environment. The tonus of our physiological systems is not static or fixed, but is ever changing. These alterations in environment must not exceed the power of the organism to adopt itself to these changes.

"I am sure that these considerations are often lost sight of in advising on the choice of a climate and that the necessity of stimulating the latent powers of resistance should always be borne in mind. This is particularly the case in rheumatic diseases, by which I mean rheumatic fever and rheumatic fibrositis. The individual whose vasomotor system readily adapts itself to changes in temperature, humidity, air cooling, etc., will rarely suffer from fibrositis and will resist many infections, while the one who is overclothed, this inhibiting the reflex mechanism, is constantly the victim of colds, aches and pains and of the kind popularly termed rheumatic. It is more advantageous, in most cases, to train the powers of reaction and adaptation by judicious hydrotherapy at home, or at a suitable spa, than to weaken them further by residence in warm climates, which are rarely equable and often treacherous. In addition, excessive exposure to the sun frequently causes stiffness, and many rheumatic patients are more comfortable on grey days than on sunny ones, and in cool summers rather than in hot. This may be due to the effect of ultra-violet radiation in producing chemical substances just beneath the skin, which pass into the general circulation. The whole problem is extremely complex and much further information is required from both hot and cold climates. I do not hesitate, however, to differ strongly from the popular view, formed on superficial and unsound bases that if the climate of these islands were one of perpetual sunshine and a temperature variation of not more than ten degrees, the health of the nation would improve. I consider that a strong case can be made out in favor of the view that our climate is the best of all possible climates for the normal Englishman."

This subject is one which must mature slowly. As medical science and its application through the humanitarian efforts of governments and private foundations removes from the tropics the dangerous diseases that are essentially tropical these regions will be more and more available for the residence of invalids who can expect to have their lives prolonged and made more comfortable by escaping the perils incident to extreme changes of weather. With this different climate there also probably goes a vast difference in the life history of germs within and without the body.

We are not unmindful of the fact that people from northern climates removing to the tropics cannot ordinarily remain for a term of years without deterioration and it may be that a suitable alternation of climate may turn out to the best. It is with a sinking heart that all of us encounter acute rheumatic endocarditis in children for we immediately visualize the thousands who will follow the disease from its onset through a life of semi-invalidism to premature death. If it should turn out to be true that these young people, by the removal to the tropics, can attain a comfortable life of greater duration, certainly, with all modern improvements in tropical sanitation, transportation and economic adjustment, it will be available to at least some of them.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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CONTROL OF RABIES

The Journal wishes to express approval of the State Board of Health's suggested ordinance for the control of rabies. All doctors should lend their influence to secure the adoption and enforcement of the ordinance, which in brief requires municipalities to license all dogs. No dog shall be licensed unless it has been given appropriate antirabic inoculations.

Five deaths within one year due to rabies fully justify this action and all physicians are asked to support the antirabies measures.

WHERE ARE WE HEADED?

Statistics seem to show that insanity—the term is used to cover all classes of mental defectives, perverts, etc.—is on the increase in this country. The disturbing factor is, that the increase is not in proportion to the population increase, but instead it is many times greater, almost a geometrical, as compared to an arithmetical progression; so much so, that if the increase ratio maintains, in two hundred years 87% of the population of the United States will be insane; while in two hundred and fifty years 123% will be in that category. This is, of course, manifestly impossible, that is, that more than the total population could be diseased. This, however, but serves to demonstrate that some features of statistics, and the results which are obtained when mathematical formulae are applied, so often brings to the statistician the term "damned liar", that many of us are prone to look askance at all statistics, as in this instance. But, despite the fact that records are better kept now than forty years ago; that many large and well-manned institutions for the care of the mentally deficient—jails, prisons and houses of detention—bring out of concealment many of those whom otherwise would not be enrolled, still one cannot gainsay that the insane and criminal increase is many times faster than the population.

It has been said many a time by educators and sociologists that the hope for the world's future lies in America. With such terrifying figures, as above given for the United States, if we believe our educators, we are bound to inquire: "Is there any hope for the future?" Despite the statistician, even if he is right, and the sociologist, who may be wrong, I believe there is hope. We, physicians, an army 160,000 strong in these United States, in addition a group of 150,000 nurses to aid us, have it in our power to place an impediment or obstruction in this apparent raceway to the madhouse.

To change this condition it will be necessary to open up to the vision of expectant mothers and hopeful fathers a picture of race betterment or at least to arouse in them a pride of race and of posterity, which if followed up, will lead to an aristocracy of race—a group aiming at mental and physical perfection, that is, eugenics. We may talk and have talked eugenics, but we have really practiced euthenics, that is, improvement of the individual, a worth while and laudable practice. We have done and are doing all we can by environment to improve the individual, but we are losing sight of the wonderful things heredity can do and also the horrible things that it is doing to the race—if we in the United States can now be called a race. As individuals, we may scoff at pride of ancestry and call those who have a "tree" and who can point to illustrious ancestors, "highbrows" or "snobs", and, with the attitude and gestures of a political spellbinder, disclaim all allegiance to the past, shouting about the wonderful future citizens we will rear. In so doing, we really show our own ignorance of heredity or display an astounding astigmatism. I doubt if a person without pride of ancestry can really have any true pride of posterity. The mother who prays that the expectant offspring may be a preacher, or the president, or a prima-donna, but who, in her heart, feels that it will be a horsethief or a harlot, could have avoided all such worries and anguish of heart and mind, by a careful investigation of her own family tree to note whether a family could safely be raised and also by a scanning of the trees of her many suitors and then electing the one in whose family were the characteristics she would see in her children.

William James has said that education's ultimate aim is to enable us "to know good men when we see them." Why not go a step farther? By education, especially along lines pertaining to heredity, we should be able, as a race, to *produce* good men. The physicians, who keep pace with the individual from the cradle to the grave, are in position to impress upon the groping young people and their parents and, again, upon the third generation with which they came in contact, the great need of careful study of themselves and also care in selection of a mate, if they would have descendants their equal or better.

Today in our junior high schools, guidance, that is, juvenile psychology, and later in the high schools, sociology is taught. For a proper evaluation of these subjects, especially the latter, eugenics should be thoroughly gone into, impressing upon the plastic mind of youth the mistakes of the past, the handicaps and possibly the crisis of the present and, lastly, the road to perfection for the future. With these two agencies, physicians and schools, functioning actively,—and we believe the initiative rests upon the physician,—in six generations this country can be peopled by the most wonderful homogenous race the world has yet seen.

It is not enough to cry with Walt Whitman: "Give us great men; other good things will follow. Give us a saner world, a better blooded

brood." We should, by precept and example do our bit toward producing this brood. Then one would not need to ask the question: "Where are we headed"?

CORRESPONDENCE

The Journal is pleased that members of the Association are taking advantage of this column to express their individual views.

The ideas of our members and comments on letters published are solicited.

SPECIAL TRAINING OFFERED

To the Editor: It is as important for a Health Department as for men in private practice to be up-to-date in the science of preventive medicine. The Health Officer, who should always be an M.D., needs special training in epidemiology, sanitation, administration, etc. The State Board of Health of Florida now can offer (thanks to the Rockefeller Foundation) fellowships to young physicians (M.D.'s), between the ages of 25 and 36 years, and in exceptional cases to men up to 40 years of age, in public health practice. Such men will be eligible for positions in county health units, city health officers or district health officers. Well trained men will have a better understanding of the difficulties of a proper care of the poor, as well as the difficulties facing the general practitioner.

We are especially interested in training young Florida men to fill Florida positions, and Florida men will be given first consideration in filling vacancies. Interested persons should communicate with the State Health Officer.

Very truly yours,
(Signed) HENRY HANSON.

PROCEEDINGS OF THE THIRTEENTH ANNUAL MEETING OF THE FLORIDA RAILWAY SURGEONS' ASSOCIATION, SARASOTA, MAY 2, 1932.

Members of the Florida Railway Surgeons' Association gathered at a round-table luncheon and conference at 12:30 p. m. Dr. Thos. H. Bates of Lake City, president, called the meeting to order and acted as toastmaster during the luncheon. The attendance was splendid and included as honor guests Mr. McCrabie and Mr. Rush of the third division of the A. C. L. Railway, both of whom gave interesting, short addresses showing the wonderful results which have been obtained by the application of safety methods. This round-table conference proved so satisfactory that the Railway Surgeons' Association will probably make it a permanent part of its annual program.

SCIENTIFIC SESSION

The scientific session was called to order by Dr. J. M. Irwin of St. Augustine, chairman of the Scientific Program Committee. The invocation was by the Reverend Mr. Reese of the Sarasota Baptist Church. Addresses of welcome were made by Dr. Joseph Halton, president of the Sarasota County Medical Society, and Honorable E. O. Smith, mayor of Sarasota, to which response was made by Dr. C. D. Christ of Orlando. The Address of the President, "Periodic Health Examinations from the Standpoint of Railway Surgeons", was then given by Dr. Thos. H. Bates of Lake City. Following the presidential address, the following papers were read and discussed:

"The Golden Age of Surgery," L. S. Oppenheimer, Tampa.
Discussion: L. M. Anderson, Lake City;
H. E. Palmer, Tallahassee;
C. D. Christ, Orlando;
J. W. Alsobrook, Plant City.

"Fractures of the Pelvis," Frank D. Gray, Orlando.
Discussion: C. D. Christ, Orlando;
Thos. H. Bates, Lake City;
J. S. Turberville, Century;
Lloyd J. Netto, West Palm Beach.

"Chronic Arthritis," Leland F. Carlton, Tampa.
Discussion: Joseph Halton, Sarasota;
J. B. Parramore, Jacksonville;
T. M. McDuffee, Manatee;
J. W. Alsobrook, Plant City.

"Are the Railroads Getting a Square Deal?" H. E. Palmer, Tallahassee.
Discussion: H. Gates, Bradenton;
L. M. Anderson, Lake City;
L. S. Oppenheimer, Tampa.

GENERAL SESSION

At the general session of the Florida Railway Surgeons' Association, the secretary was directed to draft resolutions on the death of the following members and to send copies to the families of the deceased: Drs. R. S. Lowry, Ft. Lauderdale; S. D. Rice, Gainesville; and J. Brown Farrior of Tampa.

It was moved, seconded and carried that the Railway Association express a strong sentiment against the present habit of the railroads in discriminating between local attorneys and local sur-

geons in the matter of foreign transportation. The Association took the position that local surgeons and local attorneys were of equal value to the railroads. A letter from Dr. Joseph D. Collins, chief surgeon of the S. A. L. Ry., addressed to Dr. T. H. Bates, president of the Florida Railway Surgeons' Association, stated that the Seaboard Air Line is now exchanging transportation for surgeons of their systems with the L. & N., Central of Georgia, Illinois Central, C. & O., and the C. & E. I. Railroads.

A resolution, prepared by an absent member, was presented, seeking to put the Association on record as favoring the repeal of the Eighteenth Amendment to the Constitution of the United States. After a full discussion, it was moved, seconded and carried that the Association go on record as favoring a referendum by the people.

A new constitution and by-laws were adopted at this meeting, but since their adoption, two serious oversights have been discovered, which will require additional legislation at the next meeting. Printing of the new constitution and by-laws will be withheld until these corrections can be made.

The following officers were elected for the ensuing year:

President—G. C. Tillman, Gainesville.

President-elect—Jack Halton, Sarasota.

Vice-President—Leland F. Carlton, Tampa.

Secretary-Treasurer—E. W. Warren, Palatka.

The Association has cause for real pride in this meeting. The registration exceeded that of any preceding meeting; the program was complete with the exception of the address of the guest speaker, Dr. J. Y. Roberts of the L. & N. Ry., who was detained at the last moment by a court subpoena as a witness in a railroad case; the interest was more evident and more sustained than at any previous meeting. It is felt that the organization is making real progress as well as a place for itself in organized medicine in Florida.

The following committees have been selected by the president, Dr. G. C. Tillman of Gainesville:

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NECROLOGY

John W. Alsobrook, chairman, Plant City.
E. Porter Webb, Crestview.
C. L. Davis, Okeechobee.

ARRANGEMENTS

H. A. Walker, chairman, Hollywood, together with all other railway surgeons in Broward County, who are members in good standing.

COMMITTEE MEETINGS

President Gerry R. Holden called three committee meetings at the Floridan Hotel, Tampa, July 16th and 17th.

The first meeting was scheduled for 8:00 p. m., Saturday evening, to discuss the medical relationship between the State Board of Health and the private physician. This was a preliminary meeting of a very few doctors to make plans for a larger meeting which is to be held in Orlando the early part of October. Those attending this preliminary meeting were: Gerry R. Holden, president of the Florida Medical Association; H. Mason Smith, president, State Board of Health; G. H. Edwards; Henry Hanson, State Health Officer; William M. Rowlett, secretary, State Board of Medical Examiners, and Stewart Thompson, business manager of the Association.

The second meeting was to have been of the Executive Committee, Sunday morning, at 10:30 o'clock. Since Dr. Spiers was the only member of the Committee who could attend, the president invited several doctors who happened to be in the lobby of the hotel for an informal discussion of some problems that were to have been taken up by the Committee, in order that the Committee might have the counsel and opinions of the doctors present. Those attending this meeting were: Gerry R. Holden, president; Thos. E. Buckman, Henry C. Dozier, J. M. Irwin, H. Mason Smith, Wm. H. Spiers, J. Ralston Wells, and Stewart Thompson, business manager.

The third meeting was called for 12:30 noon and was the first official meeting of the Public Relations Committee this year. The following minutes of this meeting have been prepared by Dr. J. Ralston Wells, secretary of the Committee:

"The meeting was called to order at 1:00 p. m., Sunday, July 17th, Floridan Hotel, Tampa, by the President of the Florida Medical Association, Dr. Gerry R. Holden. Those present were: Drs. Thos. E. Buckman, Henry C. Dozier, J. M. Irwin, Homer L. Pearson, H. Mason Smith and J. Ralston Wells, members of the committee; Gerry R. Holden and Wm. H. Spiers, members of the

Executive Committee; Stewart Thompson, business manager of the Association; and John S. Helms, invited guest with floor privileges.

"Dr. Holden explained the reasons for the rearrangement of the Committee.

"Dr. Buckman led a discussion concerning the press releases started by this Committee during 1931. The discussion was taken up by Drs. Smith, Dozier and Irwin. Dr. Smith stated that during this past year, the press releases were misinterpreted by the press and criticized wrongly. Dr. Dozier stated that approximately twelve papers throughout the state had responded favorably to the recent questionnaire concerning the desirability of articles to be sent as releases. Dr. Irwin stated that the Press Bureau activities should continue. A motion was made, seconded and carried, that the number of releases be limited to papers desiring them; that articles released be censored thoroughly by the committee in order to eliminate all hints of advertising; that the releases be made monthly. Dr. Helms expressed approval of the idea of carrying on press activity along the lines suggested.

"Dr. Buckman suggested that synchronous broadcasts of the same subjects be given over the State. A communication to Dr. Shaler Richardson, secretary of the Association, was read, from Major Garland Powell, director of station WRUF, Gainesville, stating that it had been a pleasure for the station to arrange for the Florida Medical Association to use its facilities, and expressed his desire to cooperate further with the Public Relations Committee. According to reports from Drs. Homer Pearson, Miami, and Wm. H. Spiers of Orlando, stations WIOD, Miami, and WDBO, Orlando, are giving time for the local county societies to broadcast regularly. Dr. Helms stated that the Tampa station had not offered to give time free, although they had asked to have medical broadcasting to be paid for at usual advertising rates. A motion was made, seconded and carried that state broadcasts by the Committee be made only from station WRUF. Local station broadcasts can be made through local county medical societies, these societies to submit their articles to the Florida Medical Association Public Relations Committee, or its representative, to be censored before broadcasting; that one copy of the article be sent to the Public Relations Committee secretary, one to the headquarters of the Florida Medical Association, Box 81, Jacksonville, as well as one copy to the local censor.

"Dr. Dozier explained the aims of last year concerning radio broadcasts over station WRUF, Gainesville. A motion was made, seconded and carried that the chairman of the Committee consult with Major Powell; that dates be designated and assigned to various members of the Association; and that subjects be made by the chairman of the Committee and president Holden and submitted to the Committee for correction and approval.

"Dr. Buckman brought up the subject of the Speakers' Bureau, one of the Committee's bureaus as originally proposed. An excerpt of the minutes of the Committee's meeting of July 5th, 1931, was read: 'Insofar as possible, when various subjects proposed are delivered before local public gatherings, a speaker will be proposed and invited from an outside town by the local society in charge of the program.' This was done to avoid local criticism. A motion was made, seconded and carried that the Public Relations Committee include in this year's program the Speakers' Bureau; that a list be secured of physicians throughout the state who would like to prepare papers for public delivery and who are able to deliver them; that after this list is prepared, the aid of the Association's Woman's Auxiliary be asked in arranging dates and places to deliver the various talks before the Women's Clubs, etc.

"The meeting adjourned at 3:00 p. m.

"J. Ralston Wells, M.D.,
"Secretary, Public Relations Committee."

STATE NEWS ITEMS

Dr. O. O. Feaster of St. Petersburg spent his vacation with his family at Highlands, N. C., during the month of July. Dr. Feaster returned via Jacksonville, visiting the president and secretary of the Association, as well as the business office.

* * *

Dr. Allen Jones of Miami is spending two months in North Carolina. He will attend several clinics en route.

* * *

Dr. John L. Williams and Miss Lila Cay Cochran were married at the home of the bride on July 28th. Dr. and Mrs. Williams were both residents of Tallahassee.

* * *

Dr. Frank Metzger of Tampa spent the month of July at Dr. Milton Cohen's Asthma Clinic in Cleveland, Ohio.

Dr. Lawrence Simcox of St. Petersburg is spending the summer in New Jersey.

* * *

Dr. A. L. Stebbins, formerly of Howey-in-the-Hills, is now located at Punta Gorda.

* * *

Dr. and Mrs. Thos. W. Hutson of Miami are spending their vacation at Rochester, Minnesota. While at Rochester, Dr. Hutson will attend the Mayo Brothers' Clinic. They will return to Miami about September 1st.

* * *

The thirty-second annual convention of the Chattahoochee Valley Medical and Surgical Association opened Tuesday, July 12th, at Radium Springs, near Albany, Georgia. This Association is comprised of doctors from three states, Alabama, Florida and Georgia. Invitations to attend the meeting were extended to every member of the Florida Medical Association. Dr. J. C. Davis of Quincy, as president, presided at the meeting.

The following papers were presented by Florida doctors:

"Renal Infections," E. S. Gilmer, Tampa; "The Treatment of the Failing Heart," M. J. Flipse, Miami; "Trichomonas Vaginalis," W. M. Rowlett, Tampa; "Coronary Disease," Herrman H. Harris, Jacksonville; "The Practical Application of Clinical Laboratory Tests," Herbert L. Bryans, Pensacola; "The Cystoscope as an Aid to Abdominal Surgery," Carol C. Webb, Pensacola; "Appendicostomy in Toxic Ileus of Pneumonia," C. D. Christ, Orlando.

Other Florida Doctors who registered and participated in the meeting were: N. A. Baltzell, Marianna; A. T. Cobb, Chattahoochee; R. B. Harkness, Lake City; D. A. McKinnon, Marianna; W. W. Massey, Quincy; J. H. Pound, Chattahoochee; J. L. Summerlin, Gainesville; W. C. Thomas, Gainesville; G. C. Tillman, Gainesville, and J. S. Turberville, Century.

* * *

Dr. and Mrs. R. H. Williams of Eustis recently spent some time at Daytona Beach.

* * *

Dr. and Mrs. J. B. Davis of Daytona Beach have moved from their home on Fairview Avenue and are now occupying their new home at 208 Magnolia Avenue.

* * *

Dr. A. H. Freeman of Ocala is spending several weeks at Waynesville, N. C.

Dr. J. H. Pierpont of Pensacola recently returned from San Diego, California, where he spent some time as the guest of his son-in-law and daughter, Lieut. and Mrs. M. M. Marple.

* * *

Dr. Meredith Mallory of Orlando is spending the month of August in Chicago, where he is visiting and studying.

* * *

Dr. and Mrs. Joseph Halton of Sarasota spent their vacation at Saluda, N. C., recently.

* * *

Dr. and Mrs. H. A. McClure of Tallahassee spent their two weeks' vacation at White Springs during the month of July.

* * *

The grounds of Scotland House, the beautiful home of Dr. and Mrs. D. W. McMillan of Pensacola, was the place selected for a benefit lawn fete given by the Family Welfare Agency. A delightful program of music and dance was enjoyed by the large group of participants.

* * *

Born to Dr. and Mrs. Clifford G. Blitch of Jacksonville, a daughter, on April 25th.

* * *

Dr. Paul K. Jenkins of Miami Beach has returned from a visit to St. Louis and Chicago.

* * *

Dr. T. W. Taylor of Sarasota recently returned from a visit in Andalusia, Ala.

* * *

Dr. and Mrs. W. B. Jordan have returned from a two weeks' vacation spent at Pass-a-Grille, Fla., and Bartow, Ga.

* * *

Dr. and Mrs. W. W. Shafer of Haines City returned recently from a two weeks' stay in Cuba.

* * *

Dr. H. P. Bevis of Arcadia spent the month of July doing post-graduate work in Chicago. He also visited the Mayo Clinic at Rochester, Minn.

* * *

Dr. and Mrs. Geo. R. Christian of Tampa spent two weeks in July at Indianapolis before going to Lake Nemahbin, Wisc., where they will remain several weeks.

* * *

The marriage of Dr. H. O. Brown of Clearwater and Miss Mary Bakas of Tampa was announced recently. Dr. and Mrs. Brown will make their home in Tampa, although Dr. Brown will also maintain an office at Clearwater.

Dr. and Mrs. John R. Pearson of Miami returned recently from a month's vacation in Indiana.

* * *

Dr. Wm. W. McKibben, Miami, deputy district governor of the Lions Club, was one of the guests of honor at a dinner party of the Miami Beach Lions Club which was held Friday evening, July 8th, at the Strath Haven Hotel, Miami Beach.

* * *

Dr. and Mrs. T. C. Kenaston of Cocoa returned recently from a visit to the north, where they spent several weeks in New York and Boston.

* * *

Dr. and Mrs. W. T. Simpson of Winter Haven were recently members of a fishing party at Pacita. They report a highly successful trip.

* * *

Dr. W. H. Dyer of Tampa opened a new hospital located at Seventh Avenue and Morgan Street the early part of July.

* * *

Dr. and Mrs. Frank D. Gray of Orlando spent the month of July at Daytona Beach.

* * *

Dr. L. V. L. Brown and family of DeLand were visitors in Daytona Beach recently.

* * *

Dr. and Mrs. G. M. Zeagler of Palatka who went by airplane to Ziegler, Georgia, the early part of July, have returned after a brief visit.

* * *

Dr. G. H. Edwards of Orlando was one of the principal speakers at the meeting of the District No. 8, Florida Nurses' Association, held recently at the Chamber of Commerce.

* * *

Dr. and Mrs. Bascom H. Palmer of Miami returned recently from a cruise to the West Indies, making brief sojourns in Panama, Jamaica and other points of interest.

* * *

Dr. Hubbard Gates of Bradenton was a visitor in Tallahassee recently.

* * *

Dr. Robley D. Newton and family of Ft. Myers left early in July for St. Louis, Mo. Dr. Newton will also go to Philadelphia and New York for special hospital work.

* * *

Dr. and Mrs. T. C. Maguire visited Louisville, Ky., during the month of July.

The marriage of Dr. J. P. Tomlinson, Jr., of Lake Wales and Miss Charlotte Bassage of Lake Charlotte took place at 11 o'clock June 30th. Dr. and Mrs. Tomlinson made a trip to Nassau and on their return will reside in Lake Wales.

* * *

Dr. and Mrs. M. C. Martin of Coral Gables, who have been residing at 1257 Avenue Venetia, have moved to 723 Avenue Camilo.

* * *

Dr. and Mrs. E. B. Hardee of Vero Beach spent their vacation in Cuba during the month of July.

* * *

Dr. and Mrs. Douglas D. Martin of Tampa were recently guests in Palmetto.

* * *

Dr. L. W. Blake and family of Bradenton spent a month recently at their beach home at Anna Maria.

* * *

Dr. and Mrs. T. H. Dillard spent a two weeks' vacation in Atlanta and Dillard, Ga., last month.

* * *

Dr. R. H. Mooty and family of Winter Haven spent a few days visiting relatives in northern Alabama during the month of July.

* * *

Dr. and Mrs. John E. Maines, Jr., of Gainesville spent their vacation at Daytona Beach.

* * *

Dr. and Mrs. Louis M. Orr, Jr., of Orlando spent a week-end recently at Daytona Beach.

* * *

Dr. M. C. Wilson of Miami attended a clinic at the Johns Hopkins Hospital, Baltimore, Maryland, during the latter part of July.

* * *

Dr. Harold E. Miller of New Smyrna returned recently from a visit with friends and relatives in Savannah, Ga.

* * *

Dr. E. J. Lawrence of Winter Garden was presented with a pen and pencil set by the Winter Garden Rotary Club at a meeting in July. Dr. Lawrence was the outgoing president of the Club.

* * *

Dr. M. M. Hannum of Eustis was the principal speaker at the Rotary Club meeting the early part of July. Dr. Hannum's subject was: "Human Life is Increasing in Length by Aid of New Discoveries Which Assist Physicians and Surgeons."

Dr. H. E. McMurray of Tampa, who practiced medicine in that city since 1926, died July 4th.

* * *

Dr. and Mrs. Roy J. Holmes of Miami attended the wedding of Mrs. Holmes' sister in Bartow, Ga., the latter part of July. From Bartow, they went to New York and on August 3rd sailed for England, Belgium, Holland, Germany and France, where Dr. Holmes will avail himself of the unusual clinical facilities offered on the 100th anniversary of the British Medical Association.

* * *

Dr. Blackburn W. Lowry of Tampa qualified for the Edison tarpon medal recently when he caught a 100-pound tarpon at the mouth of the Caloosahatchee.

* * *

Dr. and Mrs. R. C. Woodard of Miami spent their vacation the latter part of July at Highland Inn, near Hendersonville, N. C.

* * *

Dr. Waldo Horton and family of Winter Haven motored to Daytona Beach for a week-end visit recently.

* * *

Dr. Marvin Smith and family of Miami are spending a five weeks' vacation at Asheville, N. C. Before returning to Miami, Dr. Smith will visit the Mayo clinic at Rochester, Minn.

* * *

The Orange County Medical Society has requested a meeting of the members of the State Association and representatives of the State Board of Health, for Saturday, October 8th. The subject to be discussed will be "The Relationship Between the Activities of the State Board of Health and the Prerogatives of the Private Physician." This notice of the meeting is being given so that physicians may plan to attend. Full details of the meeting will be published in next month's Journal.

* * *

Dr. Earl C. MacCordy and family of St. Petersburg, are spending the summer at Newport, R. I. Dr. MacCordy will attend surgical clinics in Boston prior to his return home.

* * *

Dr. W. B. Medlin and family of Miami have returned from a vacation spent in Atlanta, Chattanooga and neighboring cities.



DR. JOHN S. HELMS

The Florida Medical Association, as a whole, mourns the death of Dr. John S. Helms, who passed away July 23, 1932.

Dr. Helms was the dean of his profession in his city and county. He represented the Florida Medical Association in the American Medical Association meetings for a number of years. During the years 1912-1913, he served as president of the Association and for many years his wise counsel was sought in all matters pertaining to the Association work. After having served the Association as its president, he continued to take a most active part in everything that concerned the destiny of the Florida Medical Association. The Association members will always remember him as being an aggressive fighter for what he thought was right and for what he thought was for the betterment of medicine in Florida and in the nation.

The following resolution was passed by the Hillsboro County Medical Society and bespeaks the feelings of members of the Florida Medical Association:

RESOLUTION

Dr. Helms was so closely associated with the joys and sorrows of the people of Tampa that the community is stricken by its loss in the passing of a man, whose helping hand could always be depended upon by the rich and the poor alike. His wonderful fund of knowledge, his marvelous skill and his unfailing sympathy were always at the service of suffering humanity. He had served faithfully and energetically every charitable organization in Tampa.

Personally Dr. Helms was a man of rare magnetism, his high sense of honor, dignity and scholarship were tempered by a sympathetic understanding of the foibles of humanity, his mere presence and healing touch came as a relief to the sick, and it was said of him he never had a patient who did not become a friend.

The Hillsboro County Medical Society feels that in the death of Dr. Helms their loss is irreparable. Dr. Helms was one of the founders of the Society, one of its first presidents, and always its loyal supporter. He rarely missed a meeting, always took part in the discussion of scientific papers, thus giving the members the advantage of his rich medical knowledge. The Society became dependent on him for the analysis of all problems and his guidance in their solution.

His intense interest was in organized medicine and its fight against quackery and state medicine. He believed in the personal ministration of the physician and it was to this noble mission he dedicated his life. Early in his practice he decided the people of Tampa should have the advantage of the most modern scientific methods of dealing with the sick. To this end he worked for the establishment of a hospital of the highest standard, realizing hospitalization was one of the most progressive steps of modern medicine. As a member, and later as chairman, of the Committee on Hospitals and Medical Education of the State Association, for years he rendered outstanding service in standardizing hospitals.

By his personal interest in his brother physicians he supported and encouraged them in their scientific advancement and was responsible for the professional attainments of many.

His entire life was a struggle to achieve. He overcame many handicaps by persistance and determination and as the years advanced became a more eager student, a more vigorous scientist until he had obtained a massive store of general and scientific knowledge, becoming a surgeon of national reputation and dean of the profession in this section. As representative of the County Medical Society in the State Association, of the State in the American Medical Association and as one of the founders and a member of the Board of Governors of the American College of Surgeons he became a power and an influence for good that will be felt for many generations.

Therefore be it resolved, That the members of the Hillsboro County Medical Society feel that in the death of Dr. John S. Helms they have lost a guide as well as a friend, that the vacancy in their membership will be filled with memories of a courageous leader always going forward to reach the ultimate truth of science.

That they extend to his sorrowing wife and family their deepest sympathy in their great loss.

Be it further resolved, That a copy of this resolution be sent the family, a copy spread on the permanent records of the Hillsboro County Medical Society, and a copy be sent to the State Medical Journal.

H. Mason Smith,
Eugene S. Gilmer,
S. H. Etheredge,
Committee.

Adopted by unanimous vote at the regular meeting of the Hillsboro County Medical Society, August 2, 1932.

Leland F. Carlton,
President.

Attest:
J. T. Cowart, Secretary.

DR. GEORGE S. STONE

The medical profession of Florida has suffered a severe loss in the death of one of its most esteemed and loyal members, Dr. George S. Stone of Fort Myers.

Dr. Stone was born in South Carolina in October, 1866; he died of lobar pneumonia in Fort Myers on June 1st, 1932. He received his medical degree from the University of Maryland in 1890. After receiving his diploma he did postgraduate work on diseases of the eye, ear, nose, and throat at Johns Hopkins and also practiced in Baltimore for eighteen months. He then went to New Freedom, York County, Pennsylvania, and practiced there until May, 1910, when he located in Punta Gorda, Florida. In 1918, he moved to Fort Myers, where he practiced for the remainder of his life. For many years he served as county physician. Dr. Stone was president of the Lee County Medical Society at the time of his death. The Florida Medical Association joins with the Lee County Medical Society in its expression of a deep sense of loss in the death of their well-loved member.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

To stimulate attendance at society meetings, the "Bulletin", official publication of the Dade County Medical Society, will mail to each member of the society a questionnaire, in effect as follows:

1. Do you attend the Medical Society meetings regularly, and by regularly we mean regularly—at least two-thirds of the meetings?
 (a) If not, why not?
 (b) If you do—why do you?
 Is it because of a sense of duty or because you enjoy the meetings?
2. Suggest some way to stimulate interest in the meetings.
3. Do you take part in the activities of the Society?
4. If not, is it because you don't want to or because you have not been asked?
5. Would you become active if you were asked?
6. Who do you think owns the Dade County Medical Society—you or Pat Roche?
7. Would you support the Bulletin better if it were in different hands?
8. Do you patronize the advertisers? If not, why not?

You will be furnished a self-addressed, stamped envelope and will not sign your name, so that you can feel free to express your views. Don't mind whose feelings you hurt but be honest. We are trying to get to the bottom of this situation. We feel that when we learn what you want, we can furnish it for you at our meetings. How about a little cooperation?

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society met at the Jacaranda Hotel, Sebring, for its regular monthly meeting, July 12th. Following the dinner, a paper on "Abnormal Eye Squints" was read by Dr. H. J. Blackmon of Tampa. A motion picture on gastric ulcers was shown and a very interesting discussion was entered into by the doctors present. The following doctors were in attendance: H. J. Blackmon, Tampa; I. W. Chandler, Avon Park; M. C. Kayton, Wauchula; George Scott McKnight, Avon Park; L. W. Martin, Sebring; A. A. Poucher, Wauchula; W. S. Pyatt, Bowling Green; and H. V. Weems, Sebring.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, Inc.

State Editor

Mrs. S. E. Driskell

1410 Windsor Place

Jacksonville, Florida

OFFICERS

Mrs. Leigh F. Robinson, President *Ft. Lauderdale*
Mrs. Eugene G. Peek, President-elect *Ocala*
Mrs. Arthur L. Walters, Vice-President *Miami Beach*
Mrs. Ernest W. Veal, Secretary-Treasurer . . . *So. Jacksonville*
Mrs. Wilburn Lassiter, Historian *Gainesville*

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EXCERPTS FROM INAUGURAL ADDRESS OF NATIONAL PRESIDENT

"In starting the work of the year there are four points to which I wish particularly to direct your attention:

"1. Business Methods.—No organization of any kind, in which the payment of dues is an obligation, can function properly without a fixed calendar date on which the treasurer's books are closed for the year. Every Auxiliary as yet unprovided with this first aid to efficiency should at once establish a fiscal year.

"To facilitate the work of keeping proper membership records the use of the treasurer's receipt books has been made mandatory, and is now practically universal. To supplement these the national Auxiliary is now inaugurating a uniform membership card filing system, also mandatory. County secretaries are requested to report annually on a form provided for the purpose all changes in the membership list. The importance of compliance with the plans for systematizing and simplifying the work of all officers, county, state and national, cannot be overemphasized.

"2. Archives.—The Auxiliary is, I firmly believe, destined to occupy so important a place in organized medicine that all details of its founding and development are of real value. How many Auxiliaries have preserved, in addition to their minutes, all the facts concerning their organization, the important preliminary correspondence, a complete membership file, a complete list of officers and committee chairmen, the names of those addressing the Auxiliary, with dates and

titles of their subjects, programs of all meetings, etc., etc.? As the vision of the future unrolls before our eyes, and while the founders are still with us to establish the facts, let us all hasten to write them down before they are lost forever.

"3. Public Relations.—How often, I wonder, are organization chairmen met with the objection that a community is 'over-organized' and that there is nothing for the Auxiliary to do? The 'over-organized' community is exactly the one in which the Auxiliary is most needed and finds its greatest opportunity. The most important work is often done through other organizations, the Auxiliary members suggesting and guiding the work along lines approved by the Medical Society and the health officials, the other organizations doing the work and paying the bills. Obviously, the more organizations such as Parent-Teacher Associations, the American Legion Auxiliary, and the Federated Clubs, etc., the wider the field for Auxiliary influence and the greater the opportunity to contribute our mite not only to community health but to the understanding by the public of the work and the ideals of the medical profession.

"4. Happiness.—We hear much of the inevitable sacrifices of the doctor's wife, only too well known to us all, but what of her rewards? The Auxiliary not only offers her unrivaled opportunities for the service of humanity but by that very service a new bond of sympathy and understanding is created between the doctor and his wife."

* * *

Mrs. L. F. Robinson, State president, was invited to be present at the meeting of the Broward County Medical Society on the night of May 25th and tell them of the meeting of the American Medical Association she recently attended in New Orleans.

Of course Mrs. Robinson did not lose the opportunity to tell of the aims and ideals of the Medical Auxiliary.

* * *

On May 10th the Volusia County Medical Auxiliary met in New Smyrna and the following new officers were installed: Mrs. Roy Howe, Daytona Beach, president; Mrs. W. C. Chowning, New Smyrna, vice-president; Mrs. Joseph Rutter, Daytona Beach, secretary-treasurer.

* * *

On May 2nd the Pinellas County Medical Auxiliary held its last meeting until the fall at the Suwannee Hotel in St. Petersburg with a splendid attendance.

Mrs. R. K. O'Brien sang several numbers during the luncheon. Annual reports were read by the retiring officers and the following new officers were elected: Mrs. J. E. Strickland, president; Mrs. A. P. Roope, first vice-president; Mrs. Prescott LeBreton, second vice-president; Mrs. W. W. Harden, recording secretary; Mrs. J. B. Quicksall, corresponding secretary; Mrs. M. H. Stuart, treasurer.

As this was just before the State association meeting, Mrs. Walter Jackson Freeman was present and gave an interesting talk on the possibilities of Auxiliary work.

Mrs. Ralston Wells of Daytona Beach was also present and talked of Auxiliary work in the State.

* * *

The Duval County Medical Auxiliary held its last meeting before summer vacation in the assembly room of the Mayflower Hotel on June 10th, with the president, Mrs. E. W. Veal, in the chair.

After routine business, Mrs. S. E. Driskell gave a review of the recent state convention and Mrs. Herrman Harris brought echoes from the A. M. A. Auxiliary meeting.

The guest speaker was Dr. Gerry R. Holden, president of the State Medical Association. He very interestingly reviewed the history of the State Association, telling of the outstanding policies that have been adopted from time to time and briefly outlined some of the plans for future activities.

He asked for the cooperation of the Auxiliary particularly in a public relations capacity, and in other ways that might present themselves during the year.

The Auxiliary greatly appreciated Dr. Holden's address.

* * *

The Dade County Auxiliary met on June 6th at the lovely home of Mrs. Arthur Walters, Miami Beach.

During the business session which followed a delightful covered dish luncheon, the Auxiliary voted a sum of money for charity. They arranged for a benefit bridge party the next week, and later on a rummage sale, the proceeds to be used for charity.

Mrs. Walters reported the recent State convention.

Mrs. Leigh F. Robinson, State president, was present and spoke on the scope of the Auxiliary.

This being the annual meeting, new officers were elected as follows: Mrs. M. J. Flipse, president; Mrs. E. J. Hall, first vice-president; Mrs. J. R. Pearson, second vice-president; Mrs. W. J. Barge, secretary; Mrs. P. J. Manson, treasurer.

The Auxiliary then adjourned for the summer months.

ADVERTISERS' NOTES

Cocomalt Is Accepted By "Council"

The following is the report of the Council on Pharmacy and Chemistry on Cocomalt, which you will find advertised elsewhere in this issue:

COCOMALT

(Sucrose, Skim Milk, Cocoa, Malt Extract, Egg and Added Vitamin D)

Manufacturer.—R. B. Davis Company, Hoboken, N. J.

Description.—A powdered food for the preparation of table beverages; contains sucrose, skim milk, cocoa, malt extract, whole egg, vanillin flavoring and added vitamin D (irradiated ergosterol).

Manufacture.—Cocoa (including added irradiated ergosterol), sucrose, and skim milk and egg powders are thoroughly mixed with malt syrup and vanillin flavoring. The mixture is dried at a relatively low temperature to avoid destruction of the vitamin and diastatic values. The finished product is ground, bolted and automatically packed in an atmosphere of carbon dioxide in hermetically sealed containers. The carbon dioxide composes about 75 per cent of the gas mixture in the container.

Analysis (submitted by manufacturer).—

	per cent
Moisture	0.8
Ash	3.2
Fat (ether extract)	2.9
Protein (noncaffeine and nontheobromine N × 6.25)	14.1
Caffeine	0.09
Theobromine	0.21
Crude fiber	1.4
Carbohydrates other than crude fiber (by difference)	77.0
Calcium (Ca)	0.34
Phosphorus (P)	0.43
Linter value	6.3

Calories.—3.9 per gram; 111 per ounce.

Vitamins.—Vitamin D is incorporated in Coco-

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Pharmacist

Laura and Adams Streets

Jacksonville, Florida

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MEMPHIS, TENN.

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HUGH W. PRIDDY, M.D.



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Florida Medical Association, Inc.

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VOLUME XIX
NO. 3

Jacksonville, Florida, September, 1932

Yearly Subscription, $3.00
Single Copy, 30c

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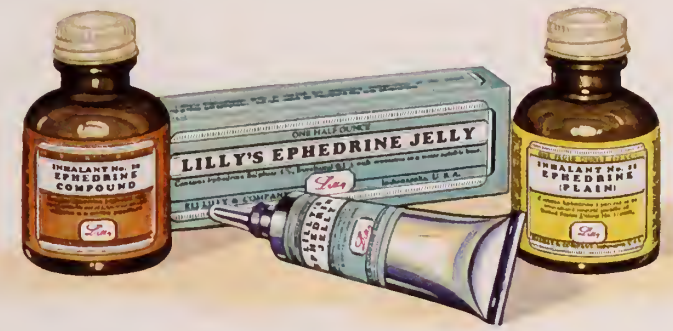
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PUBLISHED MONTHLY

Volume XXIX | Jacksonville, Florida, September, 1932 | Number 3

ROENTGENOLOGICAL EXAMINATION IN THE DIFFERENTIAL DIAGNOSIS OF ABDOMINAL PATHOLOGICAL CONDITIONS.*

FREDERICK K. HERPEL, A.B., M.D., F.A.C.P., West Palm Beach

Roentgenologic study is admitted to be a valuable aid in the analysis of the conditions causing abdominal pain. Perhaps in no field of roentgenologic work does accumulated experience and technical skill play a more important part. The great number of pathological conditions, both within the abdomen and in the adjacent portions of the body which give rise to abdominally located pain, multiplies the number of procedures necessary for their proper differentiation. Too much time and space would be required to fully enumerate the causes of abdominal pain. In some conditions the roentgenologic examination serves only to exclude organic pathology; in others it will show the cause to lie outside the abdominal cavity; in still others it will conclusively demonstrate the pathology present, and to a certain extent influence the treatment.

In roentgenologic study of the abdomen and its contents, both roentgenoscopy and roentgenography are necessary. In examination of the gastro-intestinal tract proper roentgenoscopy cannot be dispensed with, even though the roentgenologist is thereby subjected to an unusual and ever present occupational hazard. In some examinations within the abdomen, roentgenography alone will suffice. In many, both methods must be used to obtain the maximum information.

The use of special dye substances, excreted by the kidneys or the biliary tract; opaque barium meals and barium enemata; iodized oils and air injections may be used to supplement the roentgenographic examination itself.

Adherence to a definite routine method of examination will, in the majority of instances, yield the highest percentage of correct diagnoses. Economic factors will at times limit the completeness of the examination, in which event the keenness of the clinician will be required to determine which procedures will be most valuable. Here the value of the roentgenologist, as a consultant, will be at once evident. Looking at the patient as a roentgenologic subject, and with appreciation of the value of certain historical data and physical signs as leading points, he can most readily determine which of the many procedures will be most likely to be indispensible in the given case. A carefully taken and recorded history, and a carefully recorded complete physical examination, with the simpler routine blood and urine examinations should, except in emergency, precede the roentgenologic study.

I will briefly outline to you what I consider an ideal method of roentgenologic examination of a patient complaining of abdominal pain. This, of course, does not apply to those surgical emergencies where the diagnosis is evident, where specific information is desired, or where time does not permit a complete roentgenologic examination.

All roentgenologic examinations of the abdomen should be made with a fasting stomach and, if possible, after the colon has been cleared by an enema. Preliminary catharsis is seldom advisable, except in examinations of the colon. A preliminary survey of the chest by roentgenoscopy, with roentgenograms if necessary, should be made to rule out cardiac abnormalities, lung or pleural pathology, and obtain valuable information about the diaphragmatic mobility and contour. A flat roentgenogram of the abdomen, using the Bucky diaphragm, should include the gall bladder region, the urinary tract and the lumbar spine. This will determine the presence of pathology in the lumbar spine, and the presence or absence of opaque calculi in the urinary tract and gall bladder.

The esophagus is then examined by a thick barium paste, followed by the usual opaque barium-malted milk meal. It is examined for narrowing, dilatation, displacement, spasticity or filling defect. Roentgenoscopy is of much more value than roentgenography in the examination of the esophagus.

The stomach is first examined with a small

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

amount of the barium mixture, the folds of the gastric mucosa being filled by manipulation with the gloved hand or palparium spoon. By this method one can occasionally detect ulcers which would be obscured by the barium filled stomach. The completely filled stomach is then examined, by roentgenoscopy, in all projections with the patient standing, prone, supine and in the right lateral oblique position, noting the position, tonicity, mobility, peristalsis and outlines of all surfaces and contours. Roentgenoscopic examination is aided by manipulation and palpation with the examiner's hand. Constant and permanent defects of gastric outline are indicative of intrinsic pathology, either ulcer or tumor. An inconstant and variable defect of outline may be due to spasticity, extrinsic pressure or adhesions. Constant filling defects interrupt the passage of the peristaltic waves over them. Opposite the filling defect one may see a spastic incisura. At times, a penetrating ulcer will show a definite crater or niche. Ulcers are more common in the pars pylorica than in the pars media, and more common in these two parts of the stomach than in the cardiac portion. The most difficult ulcers to find are those high up on the lesser curvature in the pars media, and these are frequently seen only in the oblique projection with the patient standing.

Carcinoma of the stomach gives more or less extensive filling defects, and may be found in any part of the stomach. Interruption of peristalsis is present, a tumor can often be felt and definitely identified as a part of the stomach wall. Despite a patent or wide-open pylorus, a gastric residue will often be found after the five-hour fasting period following ingestion of the opaque meal. Only in obstruction at the pylorus is there necessarily vomiting. Many carcinomas of the greater curvature are relatively silent until they have reached large size. Benign tumors give filling defects similar to those noted with malignant tumors, and the complete study of the patient is necessary to separate them from the malignant group. Polyps in the stomach give rather striking findings, with at the same time rather atypical histories.

The normal duodenal cap is smooth in outline, rounded, conical or triangular in shape. It derives its name from its resemblance to a bishop's mitre. Ulcer of the duodenum is much more common than ulcer of the stomach. Ulcer gives a constant filling defect with an irregular outline of the duodenal cap, associated with more or less spasm of the cap and with, in the active stages, an opposing incisura. Hyperperistalsis is present in the active stage of ulcer. The pine tree deformity of chronic duodenal ulcer is one of the most characteristic pictures seen in roentgenography of the gastro-intestinal tract. Limited mobility of the duodenal cap may be due to adhesions secondary to duodenal ulcer, or secondary to gall bladder pathology. The deformity of the duodenal cap due to extrinsic causes can be overcome by palpation and manipulation of the gloved hand. The wide sweep of the duodenum seen in carcinoma of the head of the pancreas, taken in conjunction with a history of a gradually increasing painless jaundice, weakness and loss of weight, often make the probable diagnosis a certain one. Diverticula may be found in any portion of the duodenum, and are not uncommon. Barium may be retained in the diverticulum long after emptying of the stomach and small intestine.

The five-hour examination after the opaque gastric meal, with a fasting interval, gives valuable information concerning motor activity. A normal stomach should be empty well within this period. The barium-malted milk meal used by the author is usually found to have advanced to the proximal portion of the transverse colon at the end of the fifth hour. The cecum and lower small intestine are well filled, and are examined for position, size, mobility and peristalsis. Cecal mobility can usually be accurately determined at this hour.

At twenty-four hours, the small intestine should be empty and the barium scattered in irregular masses throughout the colon. The appendix may or may not be filled. If it is filled by barium it should be examined for position, mobility, and for the presence or absence of local tenderness on manipulation and deep pressure over it. Following the twenty-four-hour examination, the colon should be cleared by catharsis and enemas. A stasis in the cecal tip or the appendix after catharsis and enema, with localized tenderness on pressure over the appendix or the region of the cecal tip, are quite conclusive evidences of appendiceal pathology.

The colon is best examined by the opaque barium enema, and no roentgenologic examination of the gastro-intestinal tract is complete without such a procedure. The enema is introduced with the patient in the supine position,

little pressure is used, and if the procedure is carried out under roentgenoscopic control little difficulty will be encountered.

The manner of filling is carefully noted, with a recorded statement of the patient's symptoms during injection of the enema. Narrowing or dilatation, the position of the flexures, mobility of the various portions of the colon, the type of segmentation, anomalies and filling defects are all noted on roentgenoscopic examination and confirmed by roentgenograms. The ileo-cecal valve is frequently incompetent on distension of the cecum by the enema, but this should be recorded as it is of value in the list of secondary evidences of colon and appendiceal pathology. A spastic cecum, with hypermotility of the barium meal through the lower small intestine and the cecum, combined with local tenderness on manipulation and deep pressure in the right lower quadrant, are frequently found in patients who have intestinal tuberculosis. Anomalies of the cecum are not infrequently observed, various degrees of incomplete descent and rotation being encountered in routine examinations of this region. The position of the appendix can be predicted, even though it is not seen during the roentgenologic examination. Diverticulitis, with outpouchings of the barium mass, may be present anywhere in the colon, but is most often seen in the lower descending colon and sigmoid. Ulceration of the colon may not be recognized, except for the secondary evidences of spasticity and irritability of the affected portions of the colon. Partial evacuation of the opaque enema, with the injection of air into the colon, may enable the examiner to identify ulcers even of small size. This method appears to be valuable in patients suffering with amebic dysentery and colon ulceration.

Carcinoma of the colon gives a constant filling defect of colon outline, as shown on roentgenograms after opaque enema, with or without narrowing or constriction of the lumen. Here also a tumor, previously palpable, can be definitely located as a part of the colon. Carcinoma of the cecum and ascending colon is not rare. Less often do we find carcinoma in the transverse colon, except in the immediate region of the flexures. As one approaches the rectum the incidence of carcinoma increases, and the most commonly observed carcinomas, roentgenologically, are those near the react-sigmoid junction Limited mobility or fixation of the affected portion of the colon are not uncommon, particularly in the late stages of the disease. The roentgenologic evidences of carcinoma of the rectum are less reliable than the clinical rectal examination, and no roentgenologic report should be accepted as proof of the absence of a rectal carcinoma.

Gall bladder examination requires the use of one of the halogen salts, as tetraiodophenolphthalein, administered either orally or intravenously. I prefer the oral method and, after eight years' experience with it, see no reason to change to the intravenous method of administration which is not without its potential dangers, even though these dangers be remote. Roentgenograms made twelve hours after oral administration of the dye, with a fasting interval, should, in the normal individual, show a well filled gall bladder shadow.

Failure of dye filling within twelve hours argues for pathology of the biliary tract or the cystic duct. Non-opaque stones, not recognized on ordinary roentgenographic examination, may be shown as negative shadows in the dye filled gall bladder. Administration of a meal rich in fats (egg yolk, cream, etc.) is followed by a prompt contraction and emptying of the normal gall bladder.

In the examination of the urinary tract the injection of sodium iodide or sodium bromide, 12% to 15%, through ureteral catheters into the renal pelvis, enables the capacity of the renal pelvis and calyces to be estimated, deformities due to hydronephrosis, abscesses, tumors and calculi observed, and calculi occasionally seen as negative shadows when they were not observed on ordinary roentgenograms. Where catheterization is not possible or where obstruction exists in the lower ureter, one may administer a special dye substance intravenously which is excreted by the kidneys and gives an opacity to the excreted urine, making possible, in effect, a pyelogram without having to resort to cystoscopy and ureteral catheterization. Technical difficulties in this procedure will limit the use of this method. Cystograms with iodide or bromide, or with air, will in many instances demonstrate intracystic growths, and intracystic projections of an enlarged prostate.

In examinations of the uterus and Fallopian tubes one may inject into the uterus one of the non-toxic, non-irritating opaque oils, demonstrating the size and shape of the uterine cavity, the patency, size and course of the Fallopian tubes,

and the deformity of these structures by tumors and abscesses.

Not infrequently, after a thorough and painstaking roentgenologic examination, the clinician will receive from the roentgenologist an entirely negative report. There are patients in whom the disturbance is purely functional. It is in this type of patient that the clinician can be most charitable in his attitude toward the roentgenologist in stressing to the patient the value of this negative evidence.

All too often patients are referred to the roentgenologist prior to the taking of a history and the making of a physical examination. This places the patient, the clinician and the roentgenologist in embarrassing positions. If the roentgenologist is treated as a consultant, and so he is, the clinician should have available for discussion the history and the physical examination of the patient. The roentgenologic study is only a part of the complete study of the patient, and all facts should be considered in your analysis of any given case. The more clearly the possibilities and also the limitations of roentgenology are appreciated by the clinician the more success the clinician will have in his reference of patients. There are many conditions in which roentgenologic examination excludes organic pathology; in others it makes the probable diagnosis a certain one; in still others the roentgenologic examination while valuable if the patient can afford it, is not necessary. If the taking of a history, the physical examination and the ordinary routine blood and urine examinations precede the roentgenologic examination, the patient will be spared unnecessary expense, and more efficient service can be rendered the clinician and the patient.

If the clinician wishes the roentgenologist to increase in value to him, and to his patient, treat the roentgenologist as a consultant, give him the benefit of his knowledge and experience in the discussions relative to the patient's condition, and by healthy interchange of views and opinions stimulate a feeling of fraternalism and interest without which the relationships of clinician, roentgenologist and patient are apt to become purely commercial.

Advancement of the practice of radiology as a specialty in medicine, and as an integral part of the practice of medicine as a whole, calls for your cooperation and friendly interest. We are all primarily interested in equipping and fitting ourselves to best serve the interests of humanity. Advancement of one specialty in medicine ultimately advances the entire art of medicine. Roentgenology offers the clinician a distinct aid in the differential diagnosis of many pathological conditions, and the maximum service is rendered when clinician and roentgenologist cooperate to the fullest extent in their handling of the patient.

DISCUSSION

Dr. J. C. Dickinson Tampa:

In my opinion, the most important point made by the essayist is his warning against short cuts to diagnosis. This is as true in the field of roentgenology as in any of the other methods employed.

In the examination of a patient, too much stress cannot be laid on the importance of a well and intelligently taken history. A few years ago, there were a certain number of men, some of them roentgenologists, who felt that a roentgenologist should not be interested in histories, physical findings, or any of the other facts about a case; that he should arrive at his conclusions solely upon the shadows that could be seen on the roentgenograms, or the observations made during the fluoroscopic examination. This situation was largely brought about, in my opinion, by roentgenologists who, dividing their time between various hospitals and offices, attempted to give opinions on the accumulated material, the result of a technican's activities during their absence. Roentgenology cannot be practiced in this manner any more than any other branch of medicine. The intelligent practice of medicine requires the most intimate association between the patient and physician and the roentgenologist is no exception. My feeling in this matter is, undoubtedly, greatly influenced by the fact that I practiced general medicine for fifteen years before limiting my work to roentgenology and as for myself, I continue to practice medicine, with roentgenology as a specialty.

If best results are to be obtained, when a patient is referred to a roentgenologist, that roentgenologist must not be made to feel that he is employed on a piece work plan and that only a specified examination can be done. The relationship between him and the referring physician must be of such a nature that if, in the course of his investigation, some other procedure is indicated than that which has been anticipated, he must feel at liberty to continue his investigation along the indicated lines.

Another point that, at times, seems to be not understandable is, why two roentgenologists may

not agree upon their findings in a given case. So long as the practice of medicine is not a science but an art, just so long will physicians disagree. Roentgenologists are practicing medicine and they will have individual opinions, and disagreements are not to be taken as evidence of incompetence.

Dr. Herpel, in his paper, discussed at considerable length his particular method of doing routine gastro-intestinal examinations. In certain details the methods in our office are somewhat different. I do not know that one is particularly better than the other, but they are methods that have been worked out and are found to be satisfactory to the individual using them.

There is one point I should like to bring out in connection with the oral administration of gall-bladder dye, and that is, that in case of a non-filling gall-bladder, the dye should be repeated and I believe that it should be done the following day. It is surprising how frequently a gall-bladder that cannot be visualized in the first examination will be perfectly filled when the dye test is repeated. If this is done, I feel that there will be very few cases in which the intravenous procedure will be necessary.

In this paper, largely, conditions of a chronic nature were discussed. I should like to bring to your attention certain of the acute abdominal conditions in which the roentgenologist can be of great help. The differential diagnosis between an acute appendix and lobar pneumonia is not uncommonly extremely difficult, particularly in children. A roentgenogram of the chest will often settle the question. I have been able, on a number of occasions, to positively diagnose perforated peptic ulcers and the patient was operated upon at a much earlier period than would have been done had not a collection of air been demonstrated beneath the diaphragm making the diagnosis certain. We have all seen patients who have had their appendices removed when the real condition was a stone in the ureter. Intestinal obstructions, intussusceptions, etc., can be diagnosed with extreme accuracy by roentgenologists of experience. It is not necessary to give an opaque meal and thus delay the surgeon but, on the other hand, a diagnosis can be made early and surgical treatment instituted promptly.

Dr. Harold O. Brown, Tampa:

This paper outlines very adequately the method of a painstaking examination of the abdomen which will, when performed by a skilled roentgenologist, determine the presence or absence of pathology, and in many instances afford an exact diagnosis.

The efforts of the manufacturers of X-ray equipment to expand their field by interesting internists, surgeons and general men in installing their own equipment is doing much to discredit the specialty of roentgenology. The mere purchase of X-ray equipment no more fits the busy practitioner to make X-ray diagnoses than the owning of a Mayo Surgical Kit makes a finished abdominal surgeon. It is only by long experience, after adequate ground work, that trustworthy interpretation of fluoroscopic shadows and roentgenograms can be expected. I often hear the laity complain that X-ray films are of no value because their doctor is unable to read them. This is often only too true, but had the doctor taken the pains to explain to the patient that the interpretation of roentgenography is a distinct specialty and that he has every confidence in the ability of the roentgenologist, then the patient would feel less critical about being involved in an expensive procedure.

The busy practitioner has neither the time nor the opportunity to acquaint himself with the fine points of roentgen diagnoses, no more than he has for making highly technical pathological or bacteriological differentiations.

For the examination of the abdomen and the chest, much experience is necessary to enable the roentgenologist to recognize different pathological states and differentiate them from functional irregularities. It was only after many years of an active hospital service in X-ray that I felt at all secure in my own interpretation of gastro-intestinal findings. By following the cases through to surgery or perhaps autopsy we find our mistakes and learn the mechanical factors which mislead us.

Many doctors doing their own X-ray work feel quite competent to do their own bone work. It has been my opportunity to demonstrate several cases of Perthe's disease that had been diagnosed as hip joint tuberculoses by over-confident men. There are many other pitfalls in bone interpretation. Osgood-Schlatter's disease, Keinbock's disease, Koehler's disease and osteochondritis dissecans are quite confusing to the man of limited X-ray training. I have seen Padget's disease called osteomyelitis and unnecessary surgery instituted. I have seen amputations performed for supposed malignancies when a non-

malignant bone cyst would have been easily recognized by one of X-ray experience.

Your roentgenologist is anxious to help you in your diagnostic problems and you will rarely find one who is not sufficiently interested in his subject to qualify himself in the fine points of diagnoses.

Dr. L. J. Netto, West Palm Beach:

I would like to say one thing in compliment to Dr. Herpel for presenting this paper, as he represents more or less the younger group of physicians and surgeons.

I think from the little experience that I might have had that we often times depend too much upon the specialized group of pathologists and roentgenologists for our diagnoses, and in emphasis of what Dr. Dickinson has said the roentgenologist is an adjunct to our study of the case. Without a perfectly full and clear history, physical findings, etc., of the case he is at a loss to support us in what may be our tentative diagnosis. I might say here that an unscrupulous X-ray man told me when I first started in the practice of medicine: "Doctor, the X-ray is confirmatory." I might send a case in with suspected kidney disease, and he found it. I might send a case in with suspected gastric ulcer, and he would find that. That sort of thing put the responsibility entirely upon the X-ray man without benefit of the findings and judgment of the clinician, and at the physical expense of patient.

I appreciate Dr. Herpel's paper very much, having been associated with him in medical practice for several years. What little I might have said was in emphasis for support of a full and complete history and physical findings, and all other data pertinent to the case that might be sent to the roentgenologist for any additional information.

Dr. F. K. Herpel, West Palm Beach (concluding):

Naturally in the limited time it was impossible to cover completely a subject as large as that dealt with in this paper.

I am deeply indebted to Drs. Dickinson, Brown and Netto for their discussions. I also want to say that Dr. Dickinson's and Dr. Brown's appropriate discussions covered the points which I left out necessarily because of the limited time.

BRONCHIAL ASTHMA*

E. Sterling Nichol, M.D.,
Miami.

Asthma is a disease characterized by recurrent attacks of paroxysmal dyspnea accompanied by wheezing, cough, and a feeling of constriction in the chest. The onset of an attack is usually sudden and the patient frequently is rudely awakened from his sleep at night with an inability to breathe or, at other times, there may be the gradual "steaming up" of symptoms which seemed to start with a minor "cold in the head." The breathing is slow and expiration is particularly labored and wheezing, sometimes being quite noisy and whistling. The favorite attitude of a patient during an attack is sitting upright in bed supporting himself on his elbows or on the back of a chair, thus permitting the accessory muscles of respiration to aid in overcoming the difficult expiration. The amount of cough varies a great deal, sometimes being dry and hacking early in the attack, and later plugs of thick tenacious mucus may be brought up with considerable relief to the patient, or the attack may subside spontaneously and as relaxation occurs a quantity of frothy clear mucus may be coughed up. The duration of an attack is also quite variable, but when it is finished the patient usually feels quite normal except for a variable amount of fatigue, unless complications have developed.

The diagnosis is confirmed by finding a blood eosinophilia or the sputum may show eosinophiles. Rapid relief produced by adrenalin is sometimes an aid in diagnosis of a questionable case, where the history of previous attacks is not obtained. The differential diagnosis must include all conditions causing dyspnea, but the chief diseases to be kept in mind are bronchitis, pneumonia, new growth in the lungs or bronchi, pulmonary tuberculosis, bronchiectasis, mediastinal tumor, heart disease, including aneurysm of the thoracic aorta and functional air hunger. Maytum[1] has recently given us a careful survey of conditions which may be confused with bronchial asthma. So-called "cardiac asthma" is a misnomer and should be termed paroxysmal dyspnea and ought to be suspected in cardiac patients with myocardial disease, particularly of the left ventricle, or where there is definite coronary disease. Like true bronchial asthma the onset of the attack is

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

abrupt and likely to come on at night after the patient is asleep. The respirations are more rapid than in asthma and pulmonary edema is sometimes evidenced by auscultation. In children, the first attacks of asthma may be called bronchitis, croup or even whooping cough. It should be borne in mind that many children run fever with asthmatic attacks so that the resemblance to acute bronchitis is marked and the true condition is only established after a long period of observation. The confusion between infectious and allergic conditions in the respiratory tract of children has been the subject of a recent publication by Cohen and Rudolph[2] which deserves careful study by all clinicians dealing with children.

MECHANISM OF ASTHMATIC ATTACK

It is commonly accepted that asthma is in most instances a manifestation of a fundamental disturbance called allergy. By allergy we mean a changed capacity to react to foreign substances or a condition of specific hypersensitiveness to one or more foreign substances. Thus the allergic individual reacts differently to certain stimuli with which he comes in contact, as compared to the non-allergic or normal person. The clinical symptoms of allergy are produced by the effects on smooth muscle (myospasm) or by an increased incapillary permeability or by both effects at once, and the presenting symptom complex is characteristic, depending on the organ involved, so that either asthma or hayfever or some other constant symptom complex is produced by contact with the specific foreign agent. When this contact is interrupted the symptoms disappear.

It has been amply shown that allergy is an inherited principle, so that a positive family history of allergy occurs frequently. The specific hypersensitiveness can be shown by skin tests with the foreign substance in question. Specific substances which can produce allergic reactions are called technically "allergens" and contact is made either by way of the respiratory tract, digestive tract, skin or by infection in the case of bacteria. Allergens may be either pollens, dusts, animal epidermal substance, foods, bacteria or various other substances.

Infection in the respiratory tract is usually classed as a distinct type of causative factor in asthma, but the recent studies of Cooke[3] show that the bacteria present are true allergens. He offers as evidence the fact that infective asthma is subject to hereditary influence, and the eosinophilia is pronounced, and furthermore that local eosinophilia of histogenous origin can be demonstrated in nasal, bronchial and sinus secretions of patients with infective asthma. Since tissue eosinophilia is regarded as an indication of allergy it seems reasonable to consider infective asthma as representing an allergy to bacteria, in view of the foregoing studies. Harkavy and Hebald[4] state, after summarizing the recent work on bacterial allergy, that evidence is rapidly being accumulated to show that the allergic state is part of the immunologic mechanism accompanying infection.

Instead of defining allergy in terms of protein sensitization we should, as Vaughn[5] states, be able to discuss it in terms of intracellular activity, in terms of the physical chemistry of the individual cells located in various regions of the body. Swineford[6] has recently summarized the theory of the allergic reaction as follows: "In a hypersensitive individual allergens are brought to and unite with specific allergic antibodies (atopic reagins of coca) which are attached to the tissue cells. This allergen-antibody union results in irritating physio-chemical changes which stimulate the attached cells. When enough cells are thus stimulated there is a demonstrable local reaction. More extensive stimulation may result in general or systemic manifestations. The reaction destroys the allergen."

BALANCED ALLERGIC STATE

Individuals may be allergic many years before symptoms appear, or in case symptoms have set in they may disappear indefinitely depending on the patient's tolerance for the agent to which he is sensitive. There is a vast variation in tolerance among allergic subjects to a single specific protein. For example, all ragweed sensitive patients living in the same physical environment do not all manifest clinical signs of their allergy, that is, hayfever or asthma, at the same time. Some have a low tolerance for ragweed so develop hayfever or asthma when only a small number of pollen granules are found in the air, while others with a high tolerance present symptoms only when the pollen content of the air is quite abundant. This allergic equilibrium by means of which a person may tolerate some exposure to his specific allergen without showing symptoms thereof has been termed by Vaughn[5] as the "balanced allergic state." The final explanation of the balanced allergic state will be forthcoming

only when our conception of the pathogenesis of allergy is more complete.

The chief inhibiting factors which might prevent an allergic subject from manifesting symptoms are as follows: refractory or desensitized tissues, inadequate exposure to his allergen, exposure to insufficient number of allergens where multiple sensitization exists, or absence of non-specific aggravating factors.

NON-SPECIFIC EXCITANTS

It is generally recognized by all workers in allergy that many non-specific excitants are of great importance in the production of asthmatic attacks, either concomitant with specific sensitization or quite independent of any allergic factor. The presence or absence of the non-specific excitants offers a reasonable explanation for the phenomena of variation in individual tolerance to specific allergens. These non-specific excitants may be grouped as shown in Table I. (See page 116.)

Thus a patient may have asthma due essentially to an allergy to house dust, and yet have sufficient tolerance to dust so that he never has an attack without the concomitant excitant of overexertion for instance. That the non-specific excitant is frequently not the essential cause of the asthma is shown by the fact that desensitization of the patient with house dust will permit of overexertion without producing asthma. Or again, an asthmatic patient may have atacks on a basis of wheat sensitization primarily, and yet be made much worse by financial worry. Removal of all wheat from the diet will free him from attacks, regardless of the state of his pocketbook or the fluctuations of the stock market.

On the other hand a patient without any proven allergy may develop asthma when emotionally disturbed or on encountering a damp wind, or when subjected to extremes of heat or cold. However, Duke[7] has recently shown that even the reaction to physical agents may be truly allergic instead of non-specific. Or again, most asthmatics, with or without true sensitizations, are likely to exhibit symptoms when chemical irritants are inhaled or mechanical irritants such as road dust are encountered.

In a recent clinical analysis of the asthmatic state Baldwin[8] has stressed the importance of non-specific excitants as a class of very real stimuli to the patient with asthma. In his series of twenty-five chronic asthmatic cases all but four showed marked reactivity at some time or other during their period of observation to non-specific factors, either in conjunction with specific sensitization or alone.

The mechanism by which the non-specific excitant produces asthma has been subject to much speculation. Much has been written in late years about the so-called "detoxicating action" of the liver, a theory made popular in some quarters by Adam[9], yet no experimental proof or sound clinical analysis of this hypothetical process has been offered by Adam or others who adhere to his ideas.

Another explanation proffered of how non-specific excitants may produce asthma in the absence of a specific allergen is the theory of the trigger mechanism. By this is meant production of bronchospasm when the vagus system is stimulated, even when the stimulus is not one that would produce this effect in a normal individual, due to the preponderance of the vague over the sympathetic nervous system of the individual. The individual must be vagotonic in order for the trigger mechanism to play a part. This would explain the production of asthma in the absence of allergy, but as Steinberg[10] states: "The subject of vagus and sympathetic stimulation is still too much in the process of crystallization to draw any inferences in relation to an asthmatic attack. We do not know whether in asthma nerve stimulation actually occurs, and there is even divergent testimony as to which nerve is the constrictor and which is the dilator." This author then offers roentgenologic and pathologic proof of the theory that the asthmatic paroxysm in chronic asthma is essentially due to bronchial occlusion by mucus as a result of a hypersecretory activity of the bronchial mucous glands.

ADDITIONAL CAUSATIVE FACTORS

The foregoing group of non-specific excitants of asthma should not be confused with certain pathological conditions or disturbances of function in the asthmatic patient, the presence of which may influence to a marked degree the tendency to the asthmatic state. *First*, pathological conditions in the upper respiratory tract, such as nasal spurs or polyps may definitely play a part in the causation of asthma in some cases. However, too much emphasis must not be placed on attacks reflexly produced by means of such pathology in the so-called trigger area, for Hansel[11] has proved by studying the histopathology of the nose in asthma and hayfever that the polypi are a result of the allergic reaction in the nose, secondary to the thickening and hyperplasia of the

epithelium and the edema, round celled infiltration and connective tissue proliferation of the tunica propria and periosteal layers. Hansel states that "sinus inflammation of the non-suppurative or hyperplastic type should be considered allergic in origin unless proven otherwise. Hyperplasia and edema of the nose and sinuses interfere with the blood supply and drainage and probably make them susceptible to bacterial invasion. Sinusitis appears to be a result rather than a cause of allergic disease." On the other hand bacterial invasion may also produce *allergic* reaction, according to Cooke as noted above. Focal infection outside of the respiratory tract rarely causes asthma as a primary factor, or exerts a stimulus to subsequent attacks, according to Baldwin.[8]

A *second* intrinsic condition in the asthmatic patient which may play a part in the tendency to asthma may be spoken of as "endocrine imbalance" of which little is known. This influence is demonstrated, however, in women particularly, who have attacks with the onset of the menses, or as in some cases, the attacks disappear during pregnancy to return later. Thyroid dysfunction has long been mentioned as an influence but recent studies by Kern and Teller[12] do not indicate that the thyroid plays any part in the production of asthma. Parathyroid dysfunction may prove to be an important factor in some patients through its influence on the total calcium metabolism. The onset or termination of the asthmatic habit at adolescence or menopause also speaks clinically for an endocrine factor.

Thirdly, biochemical abnormalities undoubtedly are of importance in the production of asthma in some cases. Bray[13] reports gastric hypochlorhydria in eighty per cent of two hundred asthmatic children. The presence of gastric achylia has been noted by numerous others. Many authors have noted the infrequency of asthma and diabetes in the same patient, and Swern[14] found only six diabetics in four thousand asthmatic subjects. It is quite possible that the tendency of the diabetic toward acidosis may account for the inhibition of the asthmatic symptoms. Beckman[15] has advanced the theory of alkalosis having a causative effect on the asthmatic habit, using clinical arguments without biochemical studies. Criep[16] states in fifty asthmatic patients he could not find any changes from normal in either the CO_2 combining power or the PH of the blood.

Adam[17] contends that there is an acidotic tendency in asthma, but he does not mean an actual acidosis with a lowering of the PH beyond 7.4. He states that in adult patients he has never found any evidence of alkalosis by estimating the alkali reserve by Van Slyke's method, the figures being about the lower normal limit or even below it. In children he found apparently contradictory findings. On the other hand Tiefensee[18] maintains that in forty patients examined during the attack, the acid-base equilibrium moved to the alkaline side, and returned to normal in the free interval, as determined by studies of the CO_2 combining power, PH of the blood, PH of the urine and titrable acidity of the urine. Bray contends there is an alkalotic tendency between attacks, with a shift to the acid side as a result of the attack, during which there is freedom from asthma.

Derangement in the calcium metabolism has long been considered a factor in producing attacks of asthma, but the more recent studies of Ramirez,[19] also Kern and Teller[12] have failed to show any lowering of the total blood serum calcium, nor is there any abnormality in the diffusible and non-diffusible calcium in asthmatic subjects according to Greenberg and Gunther.[20]

Along this line of investigation is the interesting observation of Oriel and Barber[21] that during an asthmatic attack the urine contains a proteose which may be precipitated with ether and alcohol, and proof that the proteose contains the antigen responsible for the asthmatic attack is shown by positive skin tests and reproduction of the asthma by intradermal injection of the recovered proteose. Boyd[22] was able to show further that the substance recovered from the urine is an irreversibly coagulable protein and a mucoid.

It is apparent that further light needs to be thrown on the biochemical status in asthma, but it is quite likely such factors will prove to be of real importance in the causative mechanism of the asthmatic attack.

In conclusion then, one may safely state that hypersensitiveness is significant in the production of asthmatic attacks in many patients, but that infection (unless we consider this part of allergy) and non-specific excitants are responsible for some attacks and in addition certain abnormalities in the body chemistry and mechanics account for other attacks. In view of these different causative mechanisms in asthma, it is quite natural that there should be great variation in the clinical symptomatology and also a

great deal of false reasoning on the part of physician and patient alike when an attempt is made to analyse the cause of the individual attack.

ALLERGIC TREATMENT

It may be stated without fear of contradiction that more patients with chronic asthma will be relieved by thorough allergic management than by any other method of therapy. This consists first in skin testing the patient with all the allergens with which the patient may come in contact, both by scratch and intradermal methods, and then the proper evaluation by checking with the history to see whether the positive reactions are of clinical importance.

Pollens: In the case of pollen sensitization it is necessary to refer to the facts discovered in the community pollen survey in which the patient resides, for it is perfectly obvious that to desensitize a patient with a pollen that he never comes in contact with is not only useless but reprehensible. (Such a pollen survey, though incomplete, was made of southern Florida by Nichol and Durham[23] two years ago. The chief offenders were found to be the grasses, Bermuda and natal grass, while ragweed was practically of no consequence). The perennial method of desensitization with pollen extracts is pretty widely preferred over the preseasonal method, because once the patient is desensitized his immunity can be maintained by injections every two, three or four weeks. For a detailed description of pollen desensitizing methods reference should be made to any of the current books on allergy or to the recent reports by Figley[24] or Brown[25]. The results are quite satisfactory in cases where pollen sensitization is the only cause of the asthma. In a recent symptomatic comparison of groups of pollen cases without treatment and the same groups with treatment, Gay[26] reported a great decrease in the number of days of symptoms in the treated groups, thus emphasizing the economic importance of desensitizing all patients suffering pollen asthma or hayfever.

Pollen filters may also be installed in the home or office, and in slightly sensitive patients may give relief. Their chief value, however, is that of adjunct to desensitization measures. I have installed an efficient filter in the home of six asthmatic patients without appreciable improvement in any case. Rappaport, et al.,[27] recently studied thirty-one pollen asthma cases in filtered air and noted only partial relief in most cases.

Allergen chambers, as advocated by Van Leeuwen[28], are of marked benefit in some cases, probably because not only is pollen avoided, but other allergens such as dust and mold are eradicated at the same time. For practical purposes, however, the expense of installing such a chamber in a home is prohibitive.

Foods: Any food producing a repeatedly positive skin test and shown to be of clinical significance should be withdrawn from the diet. It should be kept in mind that the skin reaction is no index of the symptomatic response to a food, being only a qualitative test. The three most common offenders are wheat, milk and eggs. Even if the skin tests are entirely negative, trial diets as advocated by Rowe[29] should be used for food allergens do not always show a positive skin response. The trial diet should contain as its basis foods which are known to be seldom allergenic, and in addition no food should be included which is closely related biologically to other foods which may be or are allergenic, since the importance of the biologic grouping food allergens has been shown by Vaughn[30]. If the patient shows improvement on the trial diet, then new foods should be added singly about every third day. An accurate food diary will also frequently detect the offending food in the diet.

Many allergists do not place much importance on foods as an allergenic cause of asthma, and their attitude governs the detailed care with which they search for possible food factors. Thus Maytum[31] remarks that although a high percentage of positive tests are obtained with foods, it is difficult to prove their clinical significance without a rather long period of observation, with careful supervision of the patient's diet. On the other hand those especially interested in food allergy, such as Rowe, have had worth while results, and feel repaid for the tedious task of ferreting out food factors. Stier and Hollister[32] recently reported two-thirds of a group of 114 asthma patients as obtaining complete or nearly complete relief and dietary restriction alone was given the credit in half of the cases. Brown[33] claims excellent results not only by withdrawing offending foods, but by administration of hydrochloric or citric acid on the theory that the food is incompletely digested and therefore acts as a foreign protein.

Epidermals: In case of clinical proof of sensitization to animal hair or dander an honest attempt should be made to remove the beasts

from the environment. However, because of social demands, it is impossible to get away entirely from cats, dogs or horses. Furthermore, horse hair is found in some mattresses and upholstered furniture, likewise goat hair and cattle hair. Wool is found in many articles of clothing and materials about the home. It is well to remember that rabbit hair is freely used as a covering for toys, and is used in fur trimmings on clothing and as fake fox, ermine or sable furs. Feathers are of prime importance and all feather pillows should be removed from the home. In this regard, however, Brown[34] has called attention to the danger of substituting kapok pillows for feather ones without making sure there is no kapok sensitization. He reminds us that kapok tree and the cotton plant are botanically related, so that most persons sensitive to cotton seed are also sensitive to kapok. Desensitization measures should also be carried out in many cases of epidermal allergy, depending on the judgment of the allergist. The results are usually satisfactory.

House dust: In the event of house dust allergy, the home should be thoroughly renovated and all the dust catchers should be done away with as far as possible. An autogenous house dust extract should be made from dust collected in the patient's home, and desensitization attempted with it. Although in the past there has been considerable disagreement among allergists as to the value of house dust desensitization, the present feeling of the majority of those who have tried it is favorable. Our experience is convincing that in southern Florida house dust is of considerable importance in the production of asthma and that autogenous dust desensitization will relieve many asthmatic subjects. It is possible that in our moist warm climate an increased number of molds may be present in the dust of the average low lying home. The part that molds play in causing asthma is still unsettled, although Van Leeuwen[28] in Holland considers molds of definite importance but it is only recently that much attention has been paid to this possible source of allergy in America. Further investigation of the molds to be found in house dust is contemplated.

The pillows and mattress on which the patient sleeps should be covered with some impervious material not permitting of the collection or emanation of dust. Cohen[35] has recently reported nineteen cases of asthma found sensitive to the dusts of mattresses, but not sensitive to cotton or kapok of which they were made. Immediate relief was produced in each case by discarding the mattress and buying a new one and recurrence was prevented by covering the mattress with rubber sheeting or Dupont's satin fabricoid. Cohen believes the offending allergen in mattress dust will prove to be a mold.

Orris root: In patients with positive skin reactions to orris root, even if the clinical importance can not be demonstrated, it is well worth while to replace all face powder, face creams, hand lotions, perfumes, etc., with orris-free products. This applies not only to the asthma victim, but to others in the household. But because it is impossible to get away from orris root in the theatre, church and social gatherings, patients that are quite sensitive should be desensitized, a procedure that gives consistently good results.

Bacterial: In infective asthma autogenous vaccines made from the sputum or sinuses should be used, as popularized by Walker[36]. Thomas[37] reports better results by using in the vaccine only the organisms of the sputum which separately give a positive skin test on the patient. Whether the clinician accepts bacterial asthma as being allergic or not, vaccine treatment is indicated, acting either as a specific desensitizing antigen, or in a non-specific manner. If the laboratory facilities are not available for furnishing reliable autogenous vaccines then stock vaccines containing the bacteria most frequently found responsible in bacterial asthma should be used.

Miscellaneous: Oriel has recently used the antigen derived from the proteose in the urine of asthmatic patients as a desensitizing agent with excellent results. Further confirmation of this work is required. In the past various substances, such as tuberculin, milk, peptone, etc., have been used as non-specific desensitizing agents and a fair amount of success has been achieved by this procedure. The intravenous use of typhoid vaccine has been tried out in stubborn cases, and though the protein reaction in some patients apparently desensitizes them for a long period, yet the untoward reactions which are likely to follow this treatment hardly justified it.

In general, any definite or suspected allergen should be avoided and the patient should be acquainted enough with the allergic theory so that he can help detect the things to which he is sensitive in his own case.

In cases of physical allergy, as defined by

Duke[7], desensitization may be obtained by alternate exposure of the subject to heat and cold.

Table I: Non-Specific Excitants.

Emotional—Grief, anger, worry, fright.

Physical—Heat, cold, light.

Chemical—Irritating gases and fumes.

Mechanical—Road dust, coal dust, etc.

Atmospheric—Humidity variations, low barometric pressure, winds.

Physiological — Fatigue, constipation, menstruation, indigestion, teething.

NON-SPECIFIC TREATMENT

Nasal Tampons: The use of the Dowling nasal pack is advocated by many and its helpfulness can not be denied. This procedure is aimed at clearing up the so-called trigger area in the nasopharynx. However, one can not condone the empirical use of the procedure to the exclusion of more rational treatment.

Operative: Operative procedures may be grouped as local and neurological.

Local operations to improve asthma consist of the following: (a) Tonsillectomy, which, except in rare cases, does not benefit the patient with asthma, according to Bullen[38], who has recently made a special study of tonsillectomy in allergy. (b) Sinus operations, which are definitely indicated when infection is present and drainage and proper ventilation is interfered with. (c) Removal of polypi if proper drainage is interfered with. Hansel[11] states that following removal, radium should be used to control edema, hyperplasia and recurrence of polypoid formations. (d) Removal of septal spurs, submucous resection and cauterization of the turbinates may be done to restore proper ventilation, but conservative surgery is desirable. Too frequently the allergist receives a patient after numerous operations on the nose have failed to produce permanent relief of asthma, only to find that some specific sensitization is the essential cause and that the operations have been on the sequelae of this sensitization. In 1925 Piness and Miller[39] collected 413 allergic cases on whom 712 operations in the nose and throat had been performed. Rackemann and Tobey[40] in 1929 reviewed over a thousand cases of asthma and found that the gross results of operative treatment of the nose and throat were disappointing, affording permanent freedom from attacks in only five per cent of the cases. (e) Bronchoscopic cleansing of the large and small bronchi in patients with an exudative type of asthma has been advocated during the past few years and recently stressed by Weille[41]. However, most workers decry this procedure.

Neurological surgical procedures consist of sympathectomy or combined sympathectomy and vagotomy. There are few cases where such a formidable procedure is indicated. Stern and Spivacke[42] have reported one patient with status asthmaticus relieved to a great extent by alcohol injection of the right sympathetic from the stellate ganglion to the fourth thoracic ganglion. Probably as experience accumulates with similar procedures, they will gain in popularity.

Physiological adjustment: Hydrochloric acid is used not only in cases of food allergy as noted above, but for its acidotic effect, following the theory of an alkalotic tendency in the patient with asthma. Bray[13] finds this of special value in children. Ammonium chloride may be used for the same purpose, or routine inhalations of five percent CO_2 mixtures may be given in order to produce acidosis. The use of an acid-ash diet is also of value according to Tiefensee[18]. Calcium gluconate orally and parathormone hypodermically will also serve to keep the acid-base level shifted toward the acid side, and at the same time will raise the total and diffusible calcium of the blood serum to normal levels in case of deficiency. (In view of the notorious inaccuracy of diffusible calcium determinations it is sometimes allowable to follow this therapy even in the face of normal laboratory analyses). Glucose given in large amounts seems to be of value, probably because it assists the liver to deal with abnormal proteins derived from the digestive tract. Constipation should be scrupulously avoided, and if intestinal intoxication is suspected (i. e. due to histamine-producing bacteria) then both glucose and ammonia should be administered. In women if the asthma has started near the menopause the use of the follicular hormone of the ovary is warranted for its effect on the vagotonic manifestations.

Ultraviolet light therapy or sun bathing produces a marked physiological improvement in some asthmatics, the exact mechanism still being obscure, but the relief justified the experimental use in all cases unless known to be light sensitive. Thyroid extract may be tried in cases of proven low metabolic rates, but is usually of no value.

Fever therapy: The observation that frequently relief of asthma is obtained by the accidental contraction of various fevers, led to ex-

perimentation with induced artificial fever, first with typhoid vaccine and more recently with diathermy. Of the three recent reports on diathermic fever in the treatment of asthma, discouragement is offered by Piness and Miller[43] while Feinberg, et al.,[44] and Leopold and Stewart,[45] although not enthusiastic, believe the procedure deserves further clinical experimentation. It is quite likely that a natural fever is of more therapeutic value than diathermic fever, which instead of being a protein fever is simply an over-heat production.

Avoidance of non-specific excitants: Any of the known non-specific excitants in the individual case should be avoided as far as is humanly possible. Thus removal of a patient from a damp, chilly environment to a high, dry one is of advantage. Most asthmatic patients, no matter what their essential mechanism is, do improve at a high altitude. Over-exertion and fatigue must be guarded against. Emotional upsets should be forestalled when possible, and the physician should try to improve the mental attitude of his patient toward his disease, for the dread of future attacks is of itself sometimes a big hindrance to the ultimate improvement of the patient.

Treatment during attack: Adrenalin is the drug of choice during the attack. Ephedrine or atropine may also be used. Potassium iodide is usually helpful. Aspirin and whiskey is a favorite prescription and sometimes is quite effective. Morphine or its derivatives should never be used. Repeated reassurance from the physician and a great show of optimism on his part is of great benefit in the apprehensive asthma sufferer during an attack.

In intractable cases, so-called status asthmaticus, inhalation of five per cent CO_2 and oxygen mixtures is usually of great help. Intravenous glucose may also be an advantage at this time. In desperate cases, where adrenalin seems to aggravate the asthma and the patient is becoming exhausted and cyanotic, Maytum[46] has secured marked relief by the colonic administration of ether in olive oil.

SUMMARY

A clinical analysis of the asthmatic state has been attempted, stressing the importance of allergy, but also the influence of physiological abnormalities and non-specific excitants has been shown. Infective asthma has been considered as an expression of bacterial allergy.

The allergic management of asthma has been outlined in some detail and in addition treatment by attempting to correct physiological abnormalities and the curtailment of non-specific excitants has been evaluated. A broad view of the various methods of interrupting the habit of chronic asthma has been advocated.

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DISCUSSION

Dr. R. L. Cline, Lakeland:

What I have to say about asthma is at variance with most of what has been said. My ideas of asthma are derived from the teachings of Adams of Glasgow and Haseltine of Chicago. As they state, asthma is a by-product of two underlying basic factors, a systemic disturbance which may be metabolic, toxicosis, or endocrine, together with irritation of the vagus nerve, which set off the bronchialspasm. All asthmatics have an abnormal condition. It is a toxic condition which may arise from toxic material either engendered or formed in the normal process of metabolism or absorbed from some focus of infection. This abnormal condition is due to an improper balance between the amount of toxic material engendered within the organism or absorbed by it, and the amount removed from the organism by elimination. It has also been found that when this improper balance is corrected, either by lessening the absorption or by increasing the elimination or by both, the toxicosis tends to disappear and the asthmatic symptoms diminish in severity. This diminution of toxicosis can be demonstrated by laboratory findings.

Every individual suffering from asthma can be demonstrated to be sick long before he has developed a bronchial spasm. These patients also are subjected to one or all of the following: urticaria, eczema, erythema, vomiting, food or other sensitizations, rhinitis, high fever, or angioneurotic edema, and the like. The clinical diagnosis may be confirmed by an increased eosinophile count and by urine and blood findings.

It is pertinent here to make clear the relation between a toxic state and the condition called allergy or hypersensitization. It must not be supposed that the term toxicosis and allergy are synonymous. The toxic condition is the factor underlying all hypersensitizations, while only about one-half of the asthmatic cases can be shown to be allergic. The allergy is only one symptom of the toxicosis. And like all other sensitizations the symptoms tend to disappear when the toxicosis is controlled. That is why one individual may be sensitive to certain proteins today and tolerant tomorrow, and why many other individuals subjected to the same surroundings are never sensitive to these proteins. He is sensitive because of some systemic disturbance, metabolic, toxic, endocrine, or whatnot. And in addition to this individual being sensitive, if he now has irritation of the vagus nerve, he will also develop a bronchospasm. If he should become acutely toxic for instance, with medicinal poisoning, and fills his stomach with corn beef and cabbage, eggs or whatnot—he of course is sensitive to these foods and to other foods in this toxic condition—and likewise if he has a vagus stimulation sufficient, he will also have a bronchospasm. To my mind the safer way to handle a condition of this kind is not by desensitizing this patient to the corn beef and cabbage, but relieve that toxicosis and he will tolerate this food. To repeat: just so perfectly as you can relieve the systemic disturbance together with irritation of the vagus nerve, so perfectly can you cure every case of bronchospasm.

Dr. L. L. Whiddon, Ft. Pierce:

I don't know anything about asthma or allergy, but anything said upon asthma or allergy reminds me of a statement the great English missionary to Africa made when he came to his last day, "So much to do and so little done." When I hear doctors get up and discuss asthma and allergy it also reminds me of children dabbling in the ocean along the edge with the great sea out in front of them.

It is a very important subject and it is becoming more and more so each day as our knowledge of it widens.

It has been said that to diagnose a condition is to think of it. Now, there are hundreds of patients with asthma who have had all kinds of tests made, and yet they have not found the cause. The point to that is, the examiner has not thought of what might be the cause. I think that in every case of asthma the cause could be found if we could only think of what might be the cause.

What I got up here for was this: to bring one point before the essayist and others doing work on asthma and allergy, who might take this idea of mine and go into it in some way that might help to elucidate the cause of some asthmas. There are many causes of asthma. I was reading the other day in one of our journals where a man had been found to be sensitive to his wife's hair, (a lot of us would be glad to find that, I suppose). Therefore, it would not surprise me if some time we would find a person sensitive to the blue sky!

Regardless of what some may say, malaria is a widespread and common condition here in Florida and there is one thing I am almost sure of in my studies of asthma and allergic conditions, that is, that malaria is a very common cause of asthma and other allergic conditions. I have had very few cases, but enough to convince me that some asthma is caused by the toxins of malaria. Why should it not be? It is caused by the toxins of many other things. I had a man tell me the other day that he had a typical case of hay fever (itching of soft palate, sneezing, eyes running water, etc.) soon after a severe biting of mosquitos or sand flies. As soon as the patient would get away from them long enough (twelve hours or more) the condition would clear up. I have had a few cases of asthma that I have relieved by treating them for malaria with quinine. Now, whether I reduced their hypersensitiveness by removing the burden of malaria, or not (that could be one explanation) I believe that the malaria was the cause of the asthma.

Dr. Wm. McKibben, Miami:

The subject of anaphylaxis is one intimately affecting children and about which relatively little is known. There is much work ahead of us in properly prescribing for these little patients with eczema, and other allergic skin manifestations, sometimes with accompanying asthma, anaphylactic colds, or gastro-intestinal reactions. All of these baffle us to a large extent as to cause and treatment.

Last summer in the post-graduate work at Harvard, cases of anaphylaxis were cited in babies and children due to chocolate in the mother's diet, her use of chewing gum, her attending late dances and exciting movies, the ingestion of six to eight eggs a day on the mother's part, with resulting eczema in her baby.

It has been proven experimentally on rats, that active or passive hypersensitiveness to a foreign protein can be transmitted to offspring. Also serum from the hypersensitive woman, injected into the normal and lactating woman, developed attacks of eczema in the latter's nursing baby.

One form of allergy seen was the gastro-enteric, when the baby was first fed an artificial formula; the infant would pass into an anaphalactic shock with vomiting. Tests with the protein of cow's milk often give negative skin reactions in such cases so the cutaneous tests were not regarded as reliable.

As for treatment: Try to get breast milk or goat's milk, if baby has shock from cow's milk; or Sobee, which the baby or child soon learns to dislike or from which it may develop a diarrhea or may gain in weight very slowly. This ordinarily is used in strength of one tablespoonful to two ounces of water. In cases only slightly sensitive, using lactic acid evaporated milk, or boiling cow's milk one to six hours, or using S. M. A. desensitized non-allergic milk are effective methods.

Dr. E. Sterling Nichol, Miami (concluding):

I wish to thank the gentlemen for their discussions.

Owing to the limits of time we were unable to cover the paper entirely, and some of the points brought up were answered in the paper, and they can see it in print.

As far as Dr. Cline's detoxication theory is concerned, though I have read everything published about the detoxication theory, I must admit I am not quite able to grasp what it is all about. Every allergist, I think, believes in not having a colon full of feces, because it is quite true that the relief of constipation helps many cases whether allergic or not. And right along that line it may be of interest to Dr. Cline to know that Oriel of London has isolated from the urine of asthmatics a proteose which by skin test contains an antigen to which the patient is sensitive. And hypodermic inoculations of this proteose have offered some nice relief of asthma. But whether that is a specific or non-specific measure of treatment still remains to be shown.

PERIODIC HEALTH EXAMINATIONS FROM THE STANDPOINT OF THE RAILWAY SURGEON—A RESPONSIBILITY AND AN OPPORTUNITY*

T. H. Bates, M.D.,
Lake City.

Seventy-one years ago, when Dobell suggested the establishment of some form of periodic health examination, his was a voice crying in the wilderness. The period in which he lived and was most active was the beginning of a Renaissance period in the history of medicine and surgery. The discoveries of Pasteur, the advanced thinking of Lord Lister, the tragic demonstrations of Semmelweis, each marked an epoch in the history of medicine. None of them met immediate acceptance by the profession. So it was with the proposal of Dobell, and not until after the dawn of the twentieth century did the idea begin to take firm hold. Strange as it may seem, it remained for a layman to provide the impetus that really gave the movement its start in this country. The late Theodore Roosevelt, while president of the United States, ordered annual physical examinations of all army officers of the line of field grade. The results were so astonishing that industry began to take notice, and by 1915 we began to hear much talk of periodic health examinations. For many years now it has been customary for the railroads to require physical examinations of all applicants for positions and, with many, the practice of conducting annual examinations on certain classes of employees has become routine. As early as 1913 some railway systems carried on annual examinations of all signal men, telegraph operators, and various foremen, with the idea of determining color perception, vision, and hearing.

The executive and managerial departments realize that just as it is necessary for the mechanical equipment to be regularly inspected and required to be of given standard, so also is it desirable for the most variable factor in railway equipment to be examined and made to come up to standards. Man power is without a doubt the most variable factor in railway equipment. See a giant locomotive and string of cars as they come to a stop at a station. Immediately they are seized by a group of car inspectors, mechanics and oilers. Each performs his special examination to see whether there may be any defect, a hot box, loose journal, or a dragging brake rod. Any one of these perhaps minor defects promptly remedied will keep that train in good running order. How much more important it is that the hand that pulls the throttle be steady, or that the eye that scans the rail be clear. How important it is that the ear of the man in the signal tower be keen, that his color perception be perfect, or even that the heart of the flagman or brakeman be in good working order. To the railway surgeons then falls the responsibility of checking these human machines, the personnel of the railway system. To them falls the task of finding and giving warning of impending disasters that may result from long continued, nervous strain; of the dangers of a heart weakened by over-exertion, the probable meaning of a failing vision, or a rising blood pressure. Any one of these conditions may, as a minor defect, go unnoticed by the individual until it is too late, and, as a result, some catastrophe occurs. To the responsibility of seeing that these men are in good condition is added the golden opportunity of rendering a public service, that of aiding in the protection of the lives and property intrusted to railways for transportation, and the addition of years of usefulness to the lives of men who operate trains. There is also the opportunity for spreading health information among the railway men, and, in turn, the development of a health-mindedness among them and their families, with a view of evaluating man's most precious possession—his health. May we then, as members of a common cause, accept

*President's Address delivered before the 13th Annual Meeting of the Florida Railway Surgeons' Assn., Sarasota, May 2, 1932.

willingly the challenge that is offered by this newer phase of medical work. There is no phase or diagnosis which requires a more highly refined skill than the early discovery of minor defects, which may eventually lead to changes of the gravest and most severe character. The work is fascinating to anyone interested in either the scientific or humanitarian phase of medicine, and an opportunity is offered for any sensible, well-equipped physician to make a satisfactory examination, while the refinements of technique, judgment, and deep scientific interest can be realized no more completely than in this procedure.

SOME ASPECTS OF THYROID DISEASE*

Francis H. Langley, A.B., M.D.,
St. Petersburg.

Before taking up the diseases of the thyroid gland, it may be well to note a few of the physiological changes to which it is subject. These are based on the well-recognized relationship between the various glands of internal secretion. There is very commonly a slight enlargement at puberty. This is ordinarily transitory, although it sometimes passes into a simple goiter. Many women present a swelling of the gland during the menstrual period, the percentage being placed at from sixty to ninety by different observers. This change is slight and fleeting. Again, during pregnancy and lactation, a moderate swelling is often noted. An old belief which was widely held was that there was always a distinct enlargement of the thyroid following defloration. This observation is not confirmed by modern studies.

Inflammations and infections, though rare, occur in the thyroid gland just as elsewhere in the body. Occasionally acute thyroiditis may be due to direct bacterial invasion, when it is said to be primary, but more often it follows some acute infection as measles, scarlet fever, typhoid fever, or an inflammatory lesion of the trachea. The fever varies from 100° to 104° F., accompanied by malaise, headache, nausea, chills and leucocytosis. The gland is tense and tender and because of pressure causes dysphagia and dyspnea. Visible swelling is slight, if noted at all. Treatment consists of local application of dry cold together with symptomatic remedies. A markedly septic temperature course, or fluctuation in the gland suggests a collection of pus, calling for drainage. At times pressure on trachea and esophagus may be so great as to require surgical help. If so, simple division of the isthmus suffices.

Chronic thyroiditis may be due to tuberculosis, syphilis, actinomycosis or echinococcus infestation. A rare condition is known as Riedel's struma or chronic idiopathic thyroiditis. This is a low grade inflammation with much scar tissue formation, resulting in a gland so hard that it is usually diagnosed carcinoma. Because of the diagnostic difficulty, operation is usually performed. This is just as well for partial removal of the gland relieves symptoms of pressure and often checks the process.

Simple goiter or struma may be defined as a morbid enlargement of the thyroid gland, which occurs sporadically, epidemically, or most often endemically. The condition shows geographical variations in its incidence which are very marked. It is rarely seen near the ocean at sea level, but is common inland and especially at higher altitudes. In the Alps about ninety-five per cent of the people are affected. On this continent the condition is frequently found in the St. Lawrence River Valley, in the Great Lakes Basin, in the Mississippi Basin, throughout the Rocky Mountains and the Appalachian Mountains.

The exact cause remains unknown. However, it is closely linked with iodine deficiency. A normal gland has from 5.5 to 1. mgm. of iodine per gram. When the iodine content falls below 1. mgm. per gram, enlargement of the thyroid follows, apparently as a compensatory hypertrophy. The gland shows an increase in connective tissue and a great increase in the proportion of colloid substance to the parenchyma. There is also a decrease in the height of the epithelial cells. As involution occurs in such a gland, collections of colloid may be so marked as to form palpable nodules, or cystic degeneration may occur. Thus it is impossible to separate diffuse, nodular and cystic goiter into definite pathological groups except for certain cases where the nodules are due to parenchymatous overgrowth. The degree of enlargement varies from a very slight change to huge tumors, which overhang the sternum or extend down within the chest to the heart. Mechanically the growth may cause difficulty in breathing and swallowing, and pressure on the large vessels may cause grave circulatory embarrassment.

*Read before the Pinellas County Medical Society, Dunedin, April 21st, 1932.

As regards treatment, the main object is prevention. The majority of cases can be avoided by giving children, throughout the goiterous regions, 10. mgm. of iodide per week. In adults, when the enlargement is sufficient to be termed a goiter, reduction can be effected only by surgery. The desirability of operation depends on the inconvenience of the goiter and the pressure symptoms. Also the cosmetic improvement is important to many, especially as women and girls are affected more often than men and boys in the ratio of five or ten to one.

Hypothyroidism is a condition characterized by a slowing of all the vital processes, and results from an insufficient amount or total lack of thyroid secretion. It may well be split for consideration into two types, cretinism and myxedema.

Cretinism is a congenital disease marked by disturbances of growth, specific changes in the skin, undeveloped genitals, idiocy, deafness and enlargement of the thyroid gland. It is ordinarily found in regions where goiters are endemic. There is usually a family history of the disease. The patient is a dwarf and even when a baby looks like a "sad old man." He has widely separated eyes, broad flat nose, thick lips, marked goiter, flat chest, pot belly, and short thick arms and legs. His mentality ranges from nothing to feeble mindedness. Sexual development comes late if at all. The basal metabolic rate is low. The goiters are usually of the diffuse colloid type. Some degree of growth and intelligence may be provided by giving thyroid extract and continuing its use throughout life. Practically speaking the condition is largely of academic interest in this country.

Myxedema may be divided into three types: infantile, both congenital and acquired; idiopathic and post-operative. In a general way the symptoms and treatment are the same in all three groups. The skin becomes thickened, dry, rough and is thrown up in folds. The face seems edematous with puffing beneath the eyes and narrowing of the lid slits. Lips are thickened. Pads of fat are apt to form in the supraclavicular regions and elsewhere over the body. Sebaceous and sweat glands secrete poorly. The hair is brittle, coarse and thin. There is a subnormal temperature and the patient suffers from cold. These patients are usually anemic, have a slow pulse and are subject to arteriosclerosis. The bones in congenital and infantile myxedema are slow to ossify and grow very slowly. Dwarfs always result. Appetite and digestion are poor, constipation is the rule, and hemorrhoids and prolapse of the rectum are common. In the congenital and infantile types sexual maturity comes late or does not occur. Among adults genital atrophy is noted. Men lose potency and libido. Women suffer menstrual disorders and rarely become pregnant. The thyroid gland in congenital and infantile cases can rarely be felt. In adults it is reduced in size. There is mental dulling from the early stages. Memory is poor and thinking is slowed. The basal metabolic rate ranges from –20 to –60. These patients may well be compared to hibernating animals as regards their various functions.

The average course of the disease when untreated was five to seven years with remissions in summer and relapses in winter, ending in death.

Diagnosis, when the condition is severe, is simple. When the case is milder it becomes increasingly difficult. Congenital cases are to be differentiated from chondodystrophia by the low intelligence, from cretinism by the absence of goiter, from mongolism by the absence of the oblique eye-slits and from rickets by the normal sized epiphyses.

Treatment represents one of the bright spots in medicine and endocrine therapy. It consists of thyroid extract. The dose is started at about one grain a day and increased gradually to ten or fifteen grains. Occasionally even larger doses are required. After the desired results are obtained so far as possible, the dose is decreased to the minimum which maintains the improved status. Care must be used for at first some react badly to the drug. However, treatment must be persisted in, for only thus can help be offered. In children rapid growth results. All resume sweating, lose weight, improve mentally, and in general show a lessening of all symptoms. These results are the same in adults whether the disease is post-operative or idiopathic.

Hyperthyroidism may be defined as a disease of unknown etiology which is caused mainly by abnormally increased activity of the thyroid gland. Over one hundred years ago (1825) Caleb Parry of England first described eight cases of the disease in a posthumous article. Ten years later Sir Robert Graves described four cases, and he was able to present the matter in

such a way as to gain general recognition for it. As a result his name is still associated with the condition. It was not until 1840 that Basedow wrote on the subject, yet his name is still given to the disease throughout Germany.

The cause is unknown. It does not seem to be more prevalent in the so-called goiter districts. Apparently it is increasing in frequency, but this may be due only to the fact that it is more frequently recognized. While there are practically no age limitations, it is more commonly encountered between fifteen and fifty. There is evidence in favor of hereditary influence, but here an unstable nervous system seems to be the transmitted factor. The disease usually has an insidious onset, but some patients feel that they can date it back to a specific illness or accident. However, careful questioning will ordinarily bring out mild symptoms prior to the event named. It is not thought that iodine therapy has any causative effect. It is more likely that those cases developing while taking iodine were hyperthyroid before starting. In one experiment by Rienhoff, eight cases were followed. Two normal individuals, two with simple goiter, and four with nodular goiter were given from five to twenty minims of Lugol's solution daily for a year. Each had a normal basal metabolic rate at the start and maintained it throughout the year.

As regards pathology, the change is one of hypertrophy and hyperplasia. The gland increases from two to six times in size. In the early stages it is soft and elastic but later it becomes harder, especially after remissions and exacerbations have occurred. Iodine causes the gland to become smaller and firmer. Before iodine is given, microscopically the gland shows marked predominence of parenchyma with scant colloid. There is definite folding into layers and multiplication of epithelial cells. After iodine has been given there is a great increase in the colloid with flattening of the cells and obliteration of the folds. A clinical remission produces about the same changes in the gland as does a remission brought on by iodine.

The clinical picture described by the early writers presents the extreme condition. Most of the variations are of degree rather than nature. The disease when undisturbed runs a course of exacerbations and remissions, although the basal metabolic rate is always a little elevated during the remission. A simple division of the hyperthyroid cases may be made between those with a diffuse and those with a nodular enlargement. Others split the cases according to the presence or absence of exophthalmos.

The symptoms are so numerous and so varied that it seems to me to be simpler to present them in outline form.

I. Struma or Goiter. Always present but its size, shape and consistency vary with the stage of disease and treatment to date.

II. Signs and Symptoms referable to the nervous system.

A. Autonomic Nervous System.
 1. Eye signs.
 a. Exophthalmos, Parry's sign.
 b. Widening of the eye slits, Dalrymple's sign.
 c. Lid lag, von Graefe's sign.
 d. Infrequent winking.
 2. Cardio-vascular.
 a. Tachycardia, persistent, even in sleep.
 b. Palpitation.
 c. Usually slight rise in systolic blood pressure.
 d. Arrythmias fairly frequent.
 1) Extra systoles.
 2) Auricular fibrillation.
 3. Skin and appendages.
 a. Skin is pale, moist, thin and delicate.
 b. Increased activity of sweat and sebaceous glands.
 4. Alimentary tract.
 a. Voracious appetite.
 b. Loss of weight.
 c. Diarrhea in severe cases, (35%).
 d. Vomiting, (10-15%).
 5. Respiratory.
 a. Dry cough and hoarseness.
 b. Shallow breathing.
 c. Dyspnea, when gland presses on trachea.
 6. Genito-urinary.
 a. Polyuria.
 b. Irregular menstruation, (almost always present and quite early).

B. Central Nervous System.
 1. Nervousness.
 a. Irritability.
 b. Intolerance.
 c. Impatience.
 d. Apprehension.
 e. Insomnia.

f. Acute toxic delerium.
g. Major psychoses are not rare.
2. Headaches, usually frontal.
3. Tremor, fine and rapid.
4. Change in character.

III. Disturbances in metabolism.

A. Increase in basal metabolic rate to between +15 and +100.

B. Temperature a trifle elevated.

C. Marked emaciation, loss up to one-half of body weight.

IV. Miscellaneous.

A. Abnormal sensitivity to adrenalin. One-half cc. of 1-1000 has no effect on a normal individual, but exaggerates blood pressure, pulse and nervous symptoms of toxic goiter, (Goetsch test).

B. Blood changes.
1. Slight secondary anemia.
2. Relative lymphocytosis, (30-60%).

The most efficacious method of treatment combines medicine and surgery. Alone, either is inadequate in the majority of cases. Close cooperation between the internist and surgeon is desirable from the beginning of treatment. Because of the tendency of the disease to undergo remissions, one is apt to be misled by the effects of medical treatment. Iodine is usually given in the form of Lugol's solution, (I 5%, KI 10%). Plummer reported one series of six hundred cases where no individual was harmed by Lugol's. The basal metabolic rate drops about three to four points a day and the average drop is about forty points. Only five per cent show no change. The maximal results are usually obtained in from ten to fourteen days, but sometimes three weeks are required. The change in the basal metabolic rate closely follows the fall in the pulse rate, thus giving an easy check on the former. If iodine is stopped when maximum improvement occurs, the former symptoms promptly recur. When the iodine is thus stopped promptly, a second and even a third remission can be brought about at future dates, by resuming its use. On the other hand, if iodine is continued without interruption, the condition recurs and cannot again be affected by the use of iodine. This is important as the injudicious use of the drug may easily destroy the usual response, and thus deprive the patient of a good preparation for operation. However, when iodine is given to the point where its effectiveness is lost, the disease is not more severe than before its administration. Operation, of course, should be performed when the maximum of improvement is noted.

The dosage of Lugol's solution varies with the case. In severe cases, I usually give ten minims, four times a day. If it is given in an ounce of orange juice, the flavor is very well disguised. Following operation, Lugol's solution is given in large doses for two or three days, and then gradually reduced and finally stopped. I also like some sedative as bromide or luminal during the period of iodine therapy. Complete rest in bed is necessary during the time the patient is being prepared for operation. If headache or palpitation is too severe, ice caps to head, throat and precordium are helpful. Immediately after operation, morphine is given freely. This is very helpful but care should be used to see that the respirations do not fall below twelve to the minute. Fluids are given freely. As regards operative technique, it is too involved to treat in a paper of this length.

With regard to X-ray therapy, the results have been disappointing. However, in children approaching puberty, some good results have been obtained. My personal feeling is that X-ray makes operation more difficult, due to scar tissue and increased vascularity. There is sharp difference of opinion on this point.

In cases where surgery is contraindicated, iodine in small doses may be employed to try to induce a remission. In the aged it often helps greatly, and is to be preferred to the surgical hazard.

Malignancy of the thyroid is rare. However it occurs both as carcinoma and sarcoma. The only cases recorded as yielding surgical cure were those where the condition had not advanced far enough for clinical diagnosis, and malignancy was discovered in routine examination of the tissue by the pathologist. Operation to relieve pressure and radiation to check growth form the best combination of treatment.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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THE TONSIL PROBLEM

Since the lay press is having a good deal to say in regard to operations in general, and tonsils more especially, perhaps it is time to stop and check up to see ourselves as others see us. Any one condition that represents from thirty to forty per cent of all surgery done needs to be investigated.

Every child is born with tonsils but should every one of them be operated? Certainly, they have some function when in a normal state. We see frequently after removal that nature tries to

compensate by throwing out excessive lymphoid tissue in the pharynx and nasopharynx. As a rule, hypertrophied tonsils and enlarged adenoids are found in children that are undernourished. Is the child's poor, general condition due to the hypertrophied tonsils and adenoids or are they the result of his impaired physical make-up? Too, we are probably operating upon children too young. Before five years of age there should be some mighty good reason for operating. Adenoids, if obstructive, should be removed at any age. If not causing any symptoms perhaps they too are better left alone.

In school examinations, the eyes should have first consideration. Many a backward or dull student may improve his scholastic standing by taking care of his defective vision. However, in many schools the eyes and other physical defects are entirely ignored, though never a tonsil escapes. There are tonsil days and tonsil clinics. The tonsils are hunted as though they are a deadly enemy. In a diseased state they are, but let us not class them all as bad.

Unquestionably, the indiscriminate removal of tonsils should be checked. This may be accomplished in a measure by the more conservative laryngologists constantly bringing it to the attention of the medical profession.

ON PUBLIC EDUCATION

During the past few years there has been a great deal said and done in our Association and other medical associations about medical education for the public.

Today, more is being done to educate the public than has ever been done before. We have radio health talks; we have newspaper articles and health columns; we have public health officials who are always before the people with information on health subjects; we have all kinds of health information distributed by insurance companies, etc. Still, there is a serious doubt in our minds if the public, as a whole, really appreciates what the medical men of the state and this country are giving them.

Today, the public is better informed on medical matters than it has ever been before, yet we sometimes wonder if it has made the doctor's task any easier for him. There is some discussion on both sides of the question but we know it is easier to treat the patient who has gone to the trouble to learn something about himself and his diseases than it is to treat the ignorant and superstitious.

It is a well-known fact that free information and advice are rarely appreciated or, to say the least, rarely followed. This fact was clearly demonstrated by the attitude certain members of the press took toward our efforts to furnish them, free of charge, certain medical information which would be of interest to many of their readers. We were not only ridiculed for our efforts but were accused of trying to obtain free advertising. Still those same newspapers would pay for the syndicated health column. It is interesting to note that many of these newspapers are ever ready to print long descriptions of the miraculous cures claimed by certain notorious quacks.

We all know, too, of so many people who absorb just enough information to be wrong, and those are the ones who will insist to the last that they are right. Those are the ones, too, whom we find the most difficult to treat.

The above has been brought to your attention not to discourage you in this work but that you might more clearly see the great work that is before us.

There was a time when our fathers were traveling around in the old buggy when they felt it was best for their patients not to know too much but to depend entirely upon the old family doctor to do the right thing. In those days his was the last word. Today, the average patient is well enough informed along medical lines to know if his doctor is up to date. This is a result of medical education.

That we are accomplishing our end is definitely shown by the fact that so many persons come for vaccination against smallpox, diphtheria, typhoid, etc.; that so many come for periodic health examinations; that so many attend the tuberculosis clinics; that so many women come for prenatal care; that so many mothers ask you not to forget to put something in the baby's eyes and that there are so many inquiries concerning the prevention of disease. Therefore, let us not be "weary of well doing" but rather enter into this important phase of our work with a renewed interest and zeal determined to so educate our public that they may with more intelligence help us to help them. This is truly a great work which deserves the consideration and cooperation of every member of our Association.

CORRESPONDENCE

The Journal is pleased that members of the Association are taking advantage of this column to express their individual views.

The ideas of our members and comments on letters published are solicited.

THE RESECTOSCOPE

To the Editor: I am writing in reference to Dr. Timberlake's paper in the July issue to protest, somewhat, at his treatment of me in the history of "Transurethral Prostatotomy For Relief of Vesical Orifice Obstruction With the McCarthy Loop or Resectotome."

In the two years of my retirement I, though the originator of the method and the inventor of the resectoscope, seem to have been relegated to the position of merely one of the instrument designers and not the original one.

Now, with health restored, I intend resuming practice in De Land and feel that I must push my claim for priority both of the resection method of prostatic surgery and of the resectoscope.

I would also appreciate a notice in "The Journal" to the effect that I am "back in the ring."

Yours very truly,

(Signed) MAXIMILIAN STERN.

MEETING OF COMMITTEE ON SCIENTIFIC WORK

At the call of the chairman, Dr. L. M. Anderson, the Committee on Scientific Work met at the Blanche Hotel, Lake City, July 23rd, at 6:30 p. m. Those present were: Drs. L. M. Anderson, chairman of the Committee; Gerry R. Holden, president of the Association; Shaler Richardson, secretary-treasurer of the Association; Leland F. Carlton; Edward Jelks; and Stewart Thompson, business manager. All members of the Committee were present notwithstanding the fact that Dr. Carlton had to make a drive of nearly 200 miles to attend.

Dr. Anderson led the discussion which was participated in by those present, carefully going over many details in connection with the preparation of next year's program. The Committee approved the suggestion of the Executive Committee to start the Association's program at the next annual meeting at noon on Monday in place of Tuesday morning. It was decided to provide for twenty original papers and to divide the subject matter so that one-half of each day would be given over to general medicine and the other half to surgery.

The following letter was mailed to every member of the Association on August 18th by the Committee:

"The time of our next annual meeting at Hollywood may seem far off, but your Program Committee feels that it is not too early to begin preparations. It is requested that if you are desirous of a place on the program, you will at once submit the title of your proposed paper, a synopsis not to exceed fifty words, and the names of two members of our Association whom you wish to discuss the subject. Any application not accompanied by a synopsis cannot be considered by your Committee.

"No paper shall consume more than fifteen minutes in its delivery (discussions limited to five minutes each) which is the maximum time allowed by our by-laws. The time limit allowed for reading papers will be strictly adhered to in order that the program scheduled may be carried out and every paper read.

"Your Committee will meet the early part of January to select the papers for our next program. It is, therefore, important that you make your application before that time if you expect your proposed paper to be considered.

"It is in your power to help us materially in the preparation of a well-balanced program and your Committee feels that, as a courtesy to them, you should make an early announcement of your desires. Please make application to the chairman of the Committee, Box 81, Jacksonville. "Yours very truly,

"Committee on Scientific Work."

STATE NEWS ITEMS

Dr. and Mrs. Sherman B. Forbes of Tampa sailed September 8th for Berlin, Germany. Dr. Forbes will take a two and one-half months' course in eye, ear, nose and throat work at the University of Vienna and visit other points of interest in central Europe, returning home in about four months.

* * *

Dr. A. C. Knight and family of Jacksonville spent ten days the last of August touring the lower east coast.

* * *

Dr. and Mrs. Spencer Folsom of Orlando were recent visitors at Daytona Beach.

* * *

Dr. K. C. Thomas and family of Miami returned recently from a vacation trip in the north.

Dr. and Mrs. A. D. Draper of Tampa spent several weeks at Haven Beach during the month of August.

* * *

Dr. Henry A. Monat, Lake City, who has been spending some time in Cincinnati, Ohio, expects to sail for Vienna in the near future, to take a course in surgery in the University of Vienna.

* * *

The following is a copy of a letter dispatched to the presidents and secretaries of component societies on February 10th, the contents of which are self-explanatory:

"Reports from doctors in several parts of the state indicate that a man who calls himself M. R. James has been taking orders and receiving money as a representative of the Washington Surgical Supply Company of Washington, D. C. Please warn the doctors in your society as there appears to be no such company. In last week's Journal of the American Medical Association, page 841, the following appeared:

"'*Warning Against Swindler.* A man giving the name of M. R. James is reported to have swindled a number of physicians in Georgia by posing as a representative of the "Washington Instrument Company" of Washington, D. C. According to the report, this man offers standard medical and surgical equipment at greatly reduced prices, collects a payment and cashes checks made out to the Washington Instrument Company before leaving town. He is described as being about 35 years old, 5 feet 8 or 10 inches tall, with blue eyes and brown hair, and appears to be conversant with the business. It is suggested that physicians may protect themselves by refusing to give payments to any representative or to make out checks to them individually. The Bureau of Investigation of the American Medical Association has no record of M. R. James or of the Washington Instrument Company. Telegrams addressed to the firm were returned with the notation that there was no such firm in Washington.'

"We are taking this usual method of notifying our membership by dispatching the information to you as secretary of your society."

* * *

Dr. Arthur H. Weiland of Coral Gables was one of the principal speakers before the health committee of the Business and Professional Women's Club of Miami recently. Dr. Weiland's subject was "Reconstruction Work on Crippled Children."

Dr. C. E. Tumlin of Miami, Florida, attended clinics in Chicago and Baltimore during the summer, after which he joined his family in Waynesville, North Carolina. They returned to Miami September 1 by motor car.

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Dr. R. E. Summitt recently opened offices at 335 W. University Avenue, Gainesville. Dr. Summitt was formerly located at Eustis.

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Dr. and Mrs. A. B. Connor of Ft. Lauderdale spent several weeks in New York and Washington during the month of August.

* * *

After an extended illness, Dr. Carl H. Harrison of Cottondale, died Tuesday, August 23rd.

* * *

Dr. and Mrs. G. M. Zeagler of Palatka went to Augusta, Ga., by plane for a visit with relatives recently.

* * *

Dr. G. C. Tillman and family, Gainesville, visited in Minnesota during their August vacation.

* * *

Dr. H. D. Smith of Sanford spent one week of August in Alabama.

* * *

Dr. L. V. L. Brown of DeLand was recently appointed county physician of Volusia County. Dr. Brown was formerly located at Sebring.

* * *

Dr. O. C. Brown and family of Ft. Lauderdale spent the month of August visiting in Illinois and Wisconsin.

* * *

Governor Doyle Carlton recently announced the reappointment of Dr. Thomas W. Hutson of Miami and Dr. W. M. Rowlett of Tampa to membership on the State Board of Medical Examiners.

* * *

Dr. and Mrs. Wm. P. Farber announce the birth of a son, August 30th, at St. Petersburg.

* * *

Dr. and Mrs. Samuel Puleston of Sanford spent several weeks motoring through the northeast, including Vermont, New Hampshire and Massachusetts, last month.

* * *

Dr. T. H. Wallis and family of Ocala spent the last week of August visiting friends in Jacksonville.

Dr. J. M. Nixon of Panama City has been appointed councilor for the ninth district to fill the vacancy created by the death of Dr. D. M. Adams of that city.

* * *

Dr. H. P. Bevis of Arcadia returned the middle of August from a month's post-graduate work in radiology taken at Cook County Hospital, Chicago, and Charity Hospital, New Orleans.

* * *

Dr. Merrick D. Thomas and family of Miami, who spent the summer in Maine, motored to Auburn, Ala., recently for the purpose of entering their son in the Alabama Polytechnic. Dr. Thomas has resumed his practice at Miami.

* * *

Dr. A. G. Holmes' address is now 414 N. E. First Avenue, Miami. Dr. Holmes was formerly located at 33 N. E. 4th St.

* * *

Dr. H. Mason Smith of Tampa spent considerable time during the month of September visiting clinics in Cleveland and Chicago. On his return, Dr. Smith, who is president of the State Board of Health, stopped over in Jacksonville to confer with Dr. Henry Hanson, state health officer, and to attend staff conference with department heads Saturday morning.

* * *

Dr. and Mrs. L. L. Whiddon of Ft. Pierce spent two weeks in August visiting relatives in Tifton, Ga.

* * *

Dr. Jerome Knauer and family of Jacksonville made a trip to New York and New Hampshire during the month of August.

* * *

Dr. Robert T. Spicer and family of Miami were visitors in New York City during the latter part of August.

* * *

Dr. J. C. Chandler and family of Tampa recently spent two weeks visiting friends and relatives in northern Georgia.

* * *

At the annual meeting of the staff of Flagler Hospital, St. Augustine, the following officers were elected: president, Dr. H. E. White; vice-president, Dr. A. C. Walkup; and secretary, Dr. Reddin Britt.

Dr. J. C. Davis of Quincy spent two weeks during the month of August at Andrews and Waynesville, N. C.

* * *

Dr. Walter A. Weed of Lakeland has been appointed chairman of the Committee on Hospitals and Medical Education to fill the vacancy caused by the death of Dr. John S. Helms.

* * *

Dr. A. J. Bertram of Miami returned recently from a three months' trip through Central America where he studied tropical diseases.

* * *

Dr. and Mrs. N. W. Gable of St. Petersburg recently returned from a six weeks' visiting tour to Toronto, Montreal, Quebec, and Halifax, Nova Scotia.

* * *

Dr. and Mrs. R. E. Stevens of Sanford were recent visitors in Jacksonville.

* * *

Dr. and Mrs. I. H. Agos of Miami Beach sailed from New York the latter part of August for a two months' trip abroad.

* * *

Dr. and Mrs. Reddin Britt of St. Augustine have moved from No. 29 Shenandoah St. to No. 105 King St.

* * *

Dr. and Mrs. C. L. Park, Sanford, spent several weeks visiting friends in Georgia last month.

* * *

Dr. and Mrs. J. D. Stuart of Miami returned recently from a three months' vacation trip to California and Yellowstone National Park.

* * *

Dr. H. T. Fenn and family of Mt. Dora were recently visitors at Brooksville.

* * *

Dr. W. C. Touchton and family of Avon Park spent their August vacation in Georgia.

* * *

Dr. and Mrs. W. Lee Ashton of Umatilla announce the arrival of a baby boy, born Wednesday, August 10th.

* * *

Dr. S. C. Wood, chairman of the Underprivileged Child Committee of the Leesburg Kiwanis Club, made the principal report at the Club's Tuesday luncheon, August 16th.

* * *

Dr. and Mrs. J. N. Tolar of Sanford spent two weeks in August at Signal Mountain, Tenn.

Dr. Leroy H. Oetjen of Leesburg recently opened offices at fourth and Orange streets, having formerly been located in the Masonic building.

* * *

Dr. and Mrs. B. A. Wilkinson of Tallahassee returned recently from a tour on the Pacific coast.

* * *

Dr. Wm. D. Lithgow and family of Miami spent their August vacation in Pennsylvania and in the mountains of North Carolina.

* * *

Dr. J. H. Bickerstaff of Pensacola has changed his office location to 411 Theisen building.

* * *

Dr. W. C. Pay and family of DeLand spent their August vacation in Asheville, N. C.

* * *

Dr. Courtland D. Whitaker of Raiford recently spent ten days at Medical Field School, Carlisle Barracks, Pa. Afterwards, he was accompanied on a visit to New York City and Washington by Mrs. Whitaker.

* * *

The attention of the medical profession is called to the announcement of the Fourth Annual Assembly of the Southeastern Surgical Congress which will be held in Atlanta, Ga., March 6, 7 and 8, 1933. Begin plans now to attend. The same high class program which characterized the second and third assemblies will be provided. For further information, address Dr. B. T. Beasley, executive secretary, Doctors' Building, Atlanta, Ga.

* * *

Dr. J. R. Chandler and family of Daytona Beach returned recently from a vacation trip to Charleston, S. C.

* * *

Dr. Leroy A. Wylie of St. Petersburg was a visitor in Boston last month, where he attended surgical clinics.

* * *

Dr. Leroy H. Oetjen of Leesburg was recently appointed to the staff of the Munroe Memorial Hospital, Ocala.

* * *

Dr. J. H. Bickerstaff of Pensacola is spending some time this month at Baltimore, attending clinics.

Dr. Davis Forster has opened offices at 326 South Beach St., Daytona Beach. Dr. Forster was formerly located in New Smyrna.

* * *

Dr. Herman Watson of Lakeland has been appointed councilor for the tenth district to succeed Dr. Walter A. Weed, who has accepted the chairmanship of another committee.

* * *

Dr. J. N. Fogarty of Daytona Beach was host to a group of friends on an all-day sailing party down the river on the Dicksadee recently in celebration of Mrs. Fogarty's birthday.

* * *

The State Board of Medical Examiners held an examination at Tampa, June 13th and 14th, 1932, at which time forty applications were approved for examination. Five applications were turned down on the ground that the applicants graduated from low grade medical colleges, and three on account of the applicants' inability to speak English. Out of the forty applicants, who took the examination, there were three failures. Licenses have been granted to the following:

Anderson, Clyde O. St. Petersburg
Baker, Wilmoth H. Jacksonville
Baldor, Julian F. Tampa
Bate, James R. Nashville, Tenn.
Born, Chas. A. Pensacola
Boyden, R. W. Miami
Biff, Julin H. Elko, Ga.
Center, Raymond H. Tampa
Christis, Girard E. Pensacola
Collinworth, Allen M. Miami
Cumming, Richard C. Baltimore, Md.
Ellis, Samuel B. Valdosta, Ga.
Enzor, Rhett E. Crestview
Fleming, Richard M. Pensacola
Geringer, Albert C. Gulfport
Hardie, Dan E. Miami Beach
Harness, Andrew J. Chelyan, W. Va.
Hughes, V. A. Jacksonville
Hutchings, Ernest H. Sparta, Ga.
Johnson, Silas C. Oak Park, Ill.
King, Graham W. Jupiter
Klock, James F. Daytona Beach
McClamrock, James M. Ocala
McSwain, Gordon H. Arcadia
Mols, Edith P. Tallahassee
Moskowitz, Harry Washington, D. C.
Mosley, Robert S. Montgomery, Ala.
Perzia, Anthony P. Chicago, Ill.
Rankin, Howard P. Tampa
Safer, Jacob V. Jacksonville
Sisler, Bruce H. Pittsburgh, Pa.
Sprinkle, D. L. Mabank, Tex.
Thompson, John A. Greenville, Ala.
Valle, Antonio Fernandez Tampa
Velter, Karl W. Miami
Wood, Robert G. Lithia
Willis, H. W. Miami

Dr. and Mrs. W. J. Barge of Miami recently returned from a six weeks' visit in Asheville and Hendersonville, N. C.

* * *

Dr. W. C. Thomas and family of Gainesville, who have been residing in University Terrace recently moved to their newly constructed residence on East Seminary street.

* * *

The Orange County Medical Society will hold a special meeting in the San Juan Hotel, Orlando, on October 8, at 8 p. m.

A cordial invitation to attend this meeting is extended by the Orange County Medical Society, to all members of the Florida Medical Association and to all members and attachés of the State Board of Health.

This meeting is called to consider the bearing which the activities of the State Board of Health may have upon the prerogatives of the private practitioner and the opportunities which the private physician himself may have to aid the State Board of Health in its efforts to safeguard the health of our citizens.

There will also be a discussion concerning the activities of various philanthropic agencies which are endeavoring to provide free medical attention to indigent patients. The amount of cooperation which the private physician owes such activities and the ways in which they may possibly infringe upon private practice will also be taken up.

This discussion will be opened by Drs. H. Mason Smith, president of the State Board of Health, and Henry Hanson, State Health Officer, on the part of the State Board of Health, and by past-presidents G. H. Edwards and L. M. Anderson on the part of the Florida Medical Association. Following these speakers, there will be a general discussion from the floor.

It is to be hoped that this meeting will have a large attendance. Cooperation between the State Board of Health and the physician at large is most desirable. It can be obtained only when mutual understanding and agreement exist.

The calls which have been made upon physicians to aid in the various clinics organized by philanthropic agencies outside the medical profession is a subject of growing importance.

Certainly a frank and free discussion of these various topics will tend to give our profession a more nearly unified policy regarding our proper attitude toward these activities.

DR. WILMER CORTEZ BOX

On June 12, 1932, our fellow physician, Dr. Wilmer Cortez Box, was called to the Great Beyond, following an illness of several months.

Born near Graceville on November 5, 1884, he received his medical education at the Atlanta College of Physicians and Surgeons, 1907.

He began the practice of medicine in Graceville, where he remained in that capacity, until the time of his death.

Dr. Box married Miss Frances Simmons of Marianna in 1912. Mrs. Box and a sixteen-year-old son, Wilmer, Jr., survive him.

Dr. Box's unassuming disposition inspired confidence and devoted friendship among his associates. He was active in all civic matters and loyal to his town, county and state. He was school trustee for two terms, 1927-1931; member of the City Council from 1924-1928, during which administration the sidewalks were paved. He was President of the Jackson County Medical Society for three consecutive years, 1928-1931. He was a member of the Jackson County Chamber of Commerce. Dr. Box was vitally interested in and largely responsible for the building of State Highway No. 52 from Chipley through Graceville to the Alabama line. He was one of the largest contributors to the handsome new Methodist church building recently completed in Graceville, in which he served as steward for many years.

The following resolution on the death of Dr. Box was passed by the Jackson County Medical Society:

WHEREAS, we the members of the Jackson County Medical Society feel deeply the loss of our brother and past president, Dr. Wilmer Cortez Box;

Be it therefore resolved, that the members of this Society express their sorrow in his passing; that a copy of this resolution be spread upon our minutes as a reminder to us; that a copy be sent to his bereaved family and published in the Florida Medical Journal.

(Signed) JACKSON COUNTY MEDICAL SOCIETY.

DR. HENRY E. McMURRAY

Dr. H. E. McMurray of Tampa died in the Municipal Hospital on July 4, 1932, of disease of the coronary arteries.

Dr. McMurray was born in Charlotte Court

House, Virginia, on March 4, 1881. He received his preliminary education at Davidson College, North Carolina, and was granted the degree of Doctor of Medicine by the North Carolina Medical College.

Following his graduation, he practiced in North Carolina until 1909, when he came to Florida and located in Polk County. In the fall of 1912, he entered Tulane University and the following year received a degree from that institution. He then became resident physician in St. Luke's Hospital, Jacksonville, and also served in the City Hospital of St. Louis.

In 1929, after fifteen years of general practice, he decided to take up pediatrics and devoted two and one-half years to the intensive study of this specialty in the University of Pennsylvania Hospital, completing his work there in 1925. The following year, he came to Tampa where he successfully practiced pediatrics until his untimely death this summer.

Dr. McMurray was married in Bennettsville, South Carolina, on January 25, 1912, to Miss Annie Louise Sampson who survives him. There have been no children.

In Tampa, Dr. McMurray served on the milk commission for the city and was a member of the staff of the Children's Home, the Tampa Municipal Hospital and the Salvation Army Home. He was a valued member of the Hillsboro County Medical Society, of the State and national associations and of the Southern Medical Association. In addition to his medical connections, Dr. McMurray was a Rotarian, an Elk and a Mason. He was a member of the Hyde Park Presbyterian church, not only a member but a Christian gentleman. He worked for the good of those about him, loving his neighbor and serving the Lord.

Dr. McMurray was a man of extraordinary ability, exceptionally gifted as a pediatrician, held in the highest esteem by his fellow practitioners and by his patients. Morally, socially and professionally his life was above reproach. The following resolutions were passed by his home society:

WHEREAS, on July the 4th, 1932, the Hillsboro County Medical Society suffered the loss of one of its most beloved members in the death of Doctor H. E. McMurray after a brief illness; and

WHEREAS, Doctor McMurray has been governed during his entire professional life by the highest standard of ethics in the practice of medicine, the highest standard of morality in his private and personal affairs, has been industrious and energetic in pursuit of scientific medical knowledge and has been charitable and generous in his attitude towards his professional colleagues and his patients; and

WHEREAS, the death of Doctor McMurray has caused a void which will be long felt in our Society. His voice in our discussions and conferences will be greatly missed and the loss of his intellectual impressions, which have been so inspiring and invigorating, will be heard no more.

Be it therefore resolved, that the membership of this Society express its profound grief and extend to the family of this deceased member their deepest sympathy, that this resolution be spread upon the permanent record of the Hillsboro County Medical Society, and that a copy be sent to the family of the deceased and to the editor of the Florida Medical Journal.

(Signed) H. MASON SMITH,
S. H. ETHEREDGE,
E. S. GILMER,
Committee.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Dade County Medical Society in the club rooms of the Huntington building was called to order, August 5th, with Dr. C. F. Roche, the president, in the chair. The minutes of the previous meeting were read by the secretary and accepted as read.

The scientific program was next taken up. Dr. Ralph Gowdy presented an interesting case history, demonstrating the difficulty experienced in differential diagnosis in conditions involving the fundus of the stomach and pylorus, giving the findings as noted at operation, clinical course and a citation of several similar cases from the literature. Dr. Gerard Raap demonstrated the radiological studies of this case with a few accompanying remarks relative to the difficulty experienced by the roentgenologist in diagnosis of cases of this type. A lively discussion followed this paper, participated in by Drs. Walter Jones, J. H. Lucinian and Duncan Owens with the citation of similar cases by these members, thus evidencing the interest which Dr. Gowdy's paper aroused.

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ORANGE COUNTY MEDICAL SOCIETY

The meeting of the Orange County Medical Society was held in the Board Room of the Orange General Hospital on Wednesday evening, August 17th, President Osincup presiding.

A paper was presented by Dr. Sam Puleston, Sanford, of the Seminole County Society, discussing state medicine and the abuses of the free clinics, stressing the needed closer cooperation of the State Board of Health and the Medical Association. The paper was considered most timely and the after discussion of its features showed the appreciation of the membership in this debatable subject.

Dr. Wm. Claxton of the State Board of Health was present and told briefly the aims of the tuberculosis clinic which he would conduct the following week in Orange County.

A letter was read from Dr. Morris Fishbein, Editor of the Journal, requesting specific information regarding the proposed Orange County Medical Society's Clinic and future intentions, stating that as far as he knew, this was an innovation in the clinic rampage. It was announced that this same clinic would open September 1st, in the old Court House, Orlando.

It was decided to hold a joint meeting of the Seminole and Orange County Societies in Sanford, September 7th.

Dr. G. H. Edwards announced that a joint meeting of the Florida Medical Association and the State Board of Health, sponsored by the Orange County Medical Society, will be held in the San Juan Hotel, Saturday evening, October 8th at eight o'clock. Announcement of this meeting appears in another column.

After much discussion, the following Resolution was adopted without a dissenting vote, although two or three refrained from registering an expression:

"Any member who may advertise in a lay Journal or broadcast, without the subject matter being submitted before and approved by the Board of Censors of the Orange County Medical Society, shall be subject to suspension from the Society. This also shall apply to any member who speaks for any special method or methods of treatment advocated by any institution with which he may be connected; or who shall employ any unethical method for gaining the attention of the public for the purpose of obtaining patients."

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. L. T. Furlow entertained the Pasco-Hernando-Citrus County Medical Society at the Tangerine Hotel, Brooksville, Thursday evening, September 8th. A full course dinner was served by the hotel promptly at seven o'clock, which was followed by the scientific meeting in the parlor of the hotel.

Dr. J. T. Bradshaw read a very interesting report of a case recently under his care, which was discussed by Drs. T. F. Jackson, L. T. Furlow, also Drs. Edgar F. Fincher of Atlanta, and W. M. Hamm, of St. Louis. Dr. Bradshaw closed the discussion.

Dr. J. C. Dickinson of Tampa presented an interesting case patient, Mr. N. A., diagnosed as a giant cell tumor of upper end of tibia, with three series of X-ray pictures and results of three X-ray treatments, which showed marked improvement of condition of leg. Dr. Dickinson also showed other pictures of such tumors with marked improvement and some cured with deep X-ray therapy. This case was discussed by Dr. Palmer of Atlanta, Ga., Dr. Hamm of St. Louis, and Dr. Creekmore of Brooksville, Fla.

Dr. Hamm of St. Louis gave a very interesting report of a case of web finger and outlined form of treatment recommended, also outlined treatment for cleft palate and harelip recommending early operation.

Dr. Fincher of Atlanta gave an interesting talk of indications for spinal puncture, setting forth when they should be done. He also gave an outline of three types of head injuries and treatment for each with a caution not to do spinal puncture in shock. Also eye grounds should be carefully examined, pulse rate, respiration and blood pressure be carefully recorded.

The Society felt very much honored by having these distinguished guests with them on this occasion.

Dr. A. B. Cannon invited the Society to meet with him at Lacoochee in October.

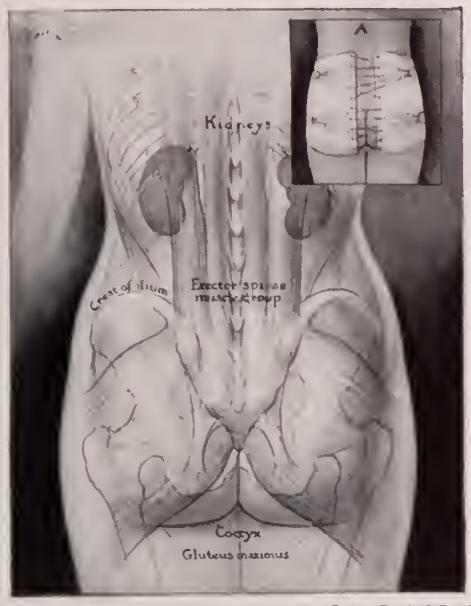
Guests present: Drs. Edgar F. Fincher, Jr., J. P. Palmer, both of Atlanta, and Wm. Hamm, of St. Louis; Drs. J.C. Dickinson, J. W. Taylor, John S. Helms, Jr., C. A. Andrews, all of Tampa.

* * *

POLK COUNTY MEDICAL SOCIETY

Members of the Polk County Medical Society and the Woman's Auxiliary of that county enjoyed an outing at Eagle Lake during the month of August.

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A MESSAGE FROM THE STATE PRESIDENT

August 19, 1932.

Dear Auxiliary Members:

This is an open letter to all of you. We are about ready to begin our active work, the summer being a vacation time for most of the county auxiliaries. Those of you who attended the convention in Sarasota know what splendid work was done last year, and how we shall have to work hard to do as well this coming year.

I have already been most favorably impressed with the cooperation of the county societies. When the president of the Florida Medical Association asked us to help in getting data regarding candidates for the legislature, all but one county president sent in the information at once. I was pleased that we were able to meet the Medical Association's request so fully and promptly. Our main reason for existence, as our name implies, is to serve the Medical Association.

There are several headings under which the year's work may be divided: first: this year we have to stress our public relations. I mention this first as I consider it of prior importance to further the relation of the doctor to the public. The doctor's wife, through her membership in various other organizations, is in a position to see that the public receives the right health information. This may be done by getting behind health programs, by obtaining health speakers and by exhibits of Hygeia. Also, our study envelopes and other health literature that we have should be properly placed. In this way, through our Public Relations Committee we should be able to bring before the public a better

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understanding of health, and the aims and ideals of the medical profession.

Second: the National Auxiliary this year is augmenting a new system of filing cards. These are to be used in all state and county auxiliaries so that the records of the National Auxiliary will be uniform and thus simplify the work of secretaries and treasurers. Before the end of this year, we should have this system in working order throughout Florida.

Third: the sale of Hygeia. This year I would ask each county auxiliary to do better than last year, as our quota is higher than the number of subscriptions obtained last year. Just a little more effort by each county auxiliary and the work will be completed.

Fourth: we shall continue to gather data about the lives and work of Florida's pioneer physicians. This part of our work is very interesting and some day will prove important in the medical history of our State.

Some of the county auxiliaries are well on the way with their plans for the year's work. Let the rest of us follow their lead so that Florida may continue to hold the place she has so ably gained in the National Auxiliary.

Faithfully yours,
DOROTHY B. ROBINSON, President.

* * *

MEDICAL AUXILIARY IN QUARTERLY MEETING

Marion County Medical Auxiliary met in July in quarterly session, coming together for luncheon at one o'clock at Indian lodge, Paradise. Mrs. J. N. Moore, president of the organization, had charge of the proceedings, and Mrs. T. H. Wallis was responsible for the unique table appointments, while Mrs. W. B. Jordan kept the record of all that transpired.

Among the items of interest that claimed the attention of those present was the report of the annual state convention, by Mrs. E. G. Peek, president-elect of the Florida auxiliary, who went to the meeting at Sarasota as a delegate from the county.

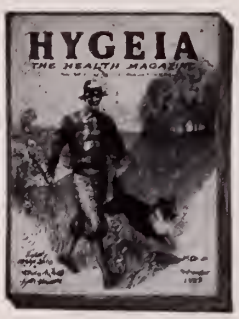
State and county organizations are asked to stress health this year, and in furthering this plan, the local auxiliary discussed suggestions for putting on a health program, and decided to offer a five-dollar gold piece as a prize to the grammar school student submitting the best essay on "Health" for a subject, during the coming school year.

Plates were laid for Mrs. Moore, Mrs. Peek, Mrs. Wallis, Mrs. Jordan, Mrs. E. G. Lindner, and Mrs. J. L. Strange of McIntosh.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	
Bay	W. J. Lee, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital	No.	
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
Lee	H. Quilllan Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May: 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	Louis Orr, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	V. M. Johnson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	No.	
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg	Every other Thurs.	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. C. Patterson, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	
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NOTE—Secretaries: Please submit information to complete the above schedule.

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VOLUME XIX
NO. 4

Jacksonville, Florida, October, 1932

Yearly Subscription, $3.00
Single Copy, 30c

THE N.Y. ACAD OF MEDICIN OCT 21 1932 LIBRARY

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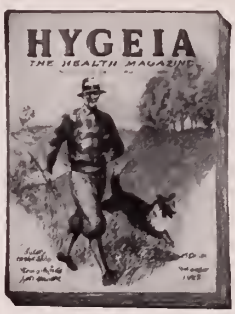
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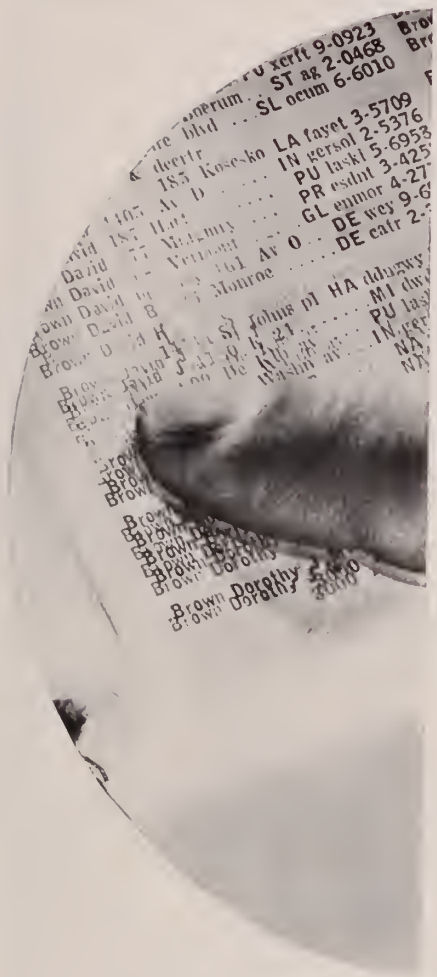
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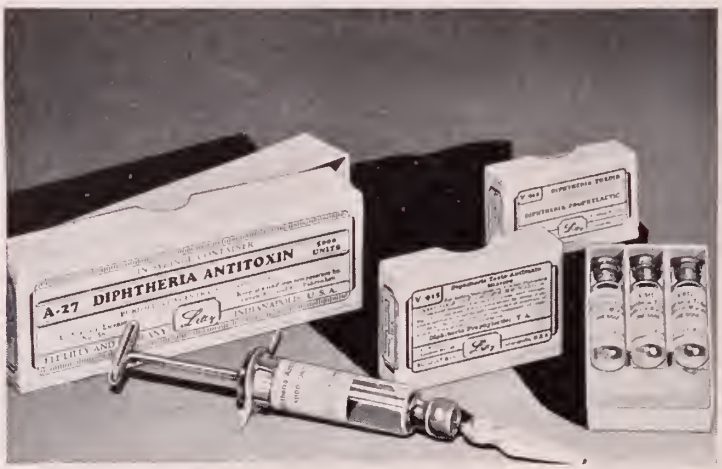
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXIX | Jacksonville, Florida, October, 1932 | Number 4

RECENT PROGRESS IN JUVENILE SINUSITIS*

M. A. Lischkoff, M.D., F.A.C.S.,
Pensacola.

The subject of juvenile sinusitis was once limited to scientific circles, but its prevalence has carried the discussion beyond rhinology and medicine. From the literature, filled with varying opinions and many contradictions, I have ventured to collect a few pertinent facts that might be of interest.

Sinusitis is probably more prevalent and certainly more readily recognized now. Richards reports from the Boston Children's hospital that in 1918 out of 2,700 patients treated in the otolaryngological department, the diagnosis of sinusitis appears four times, while in 1930, out of 7,200 cases, it appears 266 times, twenty-five times more often.

Most rhinologists believe that there is not only more sinusitis recognized but much more present today, and that juvenile sinusitis is on the increase. This is contrary to what was believed a decade ago when it was hoped that the widespread removal of tonsils and adenoids would have a tendency to check its ravages. There are many conditions linked with modern civilization that influence this.

With every head cold there must necessarily be a sinus involvement which usually clears up when the cold gets well. Carmody states that every infant who has reached one year of age, has had at least one head cold. He also believes that infection of the maxiliary and other sinuses in early life interferes with development of the frontal sinuses.

The diagnosis of sinus disease in children is often difficult. Dean believes that every child with a disturbance of the upper respiratory tract followed by fever in which no demonstrable condition of the ears or lungs is responsible, should be considered as probably having a case of residual sinusitis. Shurley demonstrated that the degree of infection was determined by the virulence of the organism, plus the resistance of the cell. Deficiency in vitamins, especially vitamin A, is of great importance, but it must be kept in mind that while a diet rich in vitamin A is essential in the treatment of sinus disease, it does not take the place of proper laryngologic treatment.

Wright states that an oversupply of accessory food factors A, C, D, does not seem to protect against sinusitis. Twenty infants were supplied over a period of months with large amounts of vitamin A. Forty under similar circumstances were given the amount of vitamin A usual in the diet of normal infants. There was no appreciable difference in the incidence of upper respiratory infection in the two groups. He concluded that vitamin A in excessive amounts does not protect infants against respiratory infections.

Rimpau concludes that head colds are associated with chilling, streptococci, staphylococci, pneumococci, and for the common cold Kruse's Ultravirus are the organisms usually held to blame. The organisms occur so commonly on the mucous membrane of the respiratory tract that they are usually regarded as saprophytes. In the diseases associated with the effects of cold, the host and not the bacterium undergoes the necessary modification.

Recent experiments tend to prove that the contagious cold in humans is caused by an invisible, uncultivable, filtrable virus. Colds can be transmitted from man to animal and human to human by means of the Berkefeld filtrates of nasal washings obtained from individuals suffering from colds; they resemble those contracted naturally.

According to Hilding the etiology falls into two groups, colds caused by exposure, and colds caused by infection. They may be interrelated.

The normal sinus is usually sterile. The normal secretions of the sinuses are grayish viscous fluid that bathes the entire mucous membrane, protecting it and assisting the ciliated epithelium in the removal of foreign substances. The mucus is probably not bacteriocidal in action, has little or no germicidal power but produces active phagocytosis induced by the power of the saliva to stimulate the migration of leucocytes. The bacterial flora of a diseased sinus changes continuously.

Chilling the body permits the invasion of

*Read before the 59th Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

pathologic organisms by lowering resistance while chilled. Joseph Klemperer attempted to determine the role played by chilling during a "cold"; he tried to determine the relationship between "getting a chill" and "catching a cold." He and most authorities believe the existence of diseases arising from chill.

It is now believed that the central heating plant is the cause of a great deal of sinus disease as there is not enough moisture left in the atmosphere. Many practicing in western Texas and Arizona believe that a warm, dry climate is the most favorable to healing sinusitis; most authors think it is a combination of sunshine with its ultraviolet and infra red therapy and absence of extreme temperature variations and the ability to be out of doors which increases body resistance. Ultraviolet light therapy, although valuable, is a poor substitute for sunshine and fresh air in which a child can get the proper amount of outdoor exercise.

The recognition of sinus disease of allergic origin is based upon clinical and histopathologic evidence. Allergic sinus diagnosis is made from the history, examinations, cutaneous tests, and findings of eosinophiles in nasal secretions. A finding of more than 10% eosinophiles in the nasal discharge indicates allergy. An edematous mucosa is the outstanding physical sign.

Allergic rhinitis and sinusitis being a distinct clinical entity, require allergic treatment, the most important of which are specific and nonspecific protein therapy, epinephrine and ephedrine.

Hilding found in studying ciliary activity and course of secretion currents in the nose, that drainage is all back to the naso-pharynx. The rate of motion varies; it is comparatively slow in the anterior third of nose; more rapid in the posterior two-thirds; rate over active area may be as high as ten millimeters a minute. These regions are motivated directly by ciliary action. The areas of slow movement in the anterior third occur where the currents of inflowing air strike the mucous membrane. Drainage from these areas is secured through traction of the mucinous covering and attains a speed of only a few millimeters per hour. The active areas on the septum drain straight back or down to the floor and then to the soft palata. The course of secretions is different than that followed by air. The greatest speed of ciliary action is found in those areas best protected from force of flow of respiratory air. The best protected areas occur in the meatuses. The direction of any given current can be altered by ephedrine placed in a neighboring region. The ephedrine stimulates ciliary action and currents are drawn toward stimulated regions. When it reaches the posterior nose, swallowing draws it in the esophagus. Besides swallowing, there is continued downward traction on the mucinous lining of the whole naso-pharynx. Direction and rate of drainage of the mucous secretions from the frontal sinus was also studied after the sinuses were unroofed. Flow direction was found to be independent of gravity. Rate of flow was two to eighteen millimeters a minute and the rate accelerates as the ostium is approached. Wenner found that the cilia movement in antra mucosa stops when alizarin citrate or oxalate is added to the medium. From his experiments it appeared that calcium is necessary for the normal movement of the cilia and when calcium precipitating substances are used, there is cilia paralysis.

It is definitely proven that the mucous membrane lining the sinus, regenerates after a radical antrum operation; if all the membrane is removed, it can grow in from the ostium. Recently Stein drained the antra in more than four hundred children as a routine after tonsil and adenoid operations. It was done under the same anesthetic, and he said it was safe and gave no untoward results. Most clinicians are opposed to indiscriminate puncturing of the antrum, as the contents of nearly 90% of all normal sinuses are believed to be sterile.

Lewis found the blood pressure outstandingly abnormal with respect to systolic level, pulse pressure and stability. High systolic pressure was the rule and the basal metabolic rate was low in a series of sinus cases recently observed.

Pugh found a correlation between the type of sinus content and its reaction. The foul broken down cloudy return from an acute or recrudescent sinusitis, almost always has an acid reaction, relative to the normal pH of 7.5, the pH varying from 6.9 to 7.4. On the other hand the healing sinus which tends to have a firm clot of mucopus, has a pH varying from 7.5 to 8.1, so that the use of alkaline lotions in irrigation of infected sinuses may have biochemical as well as mechanical reasons for its employment.

In his examination of 101 sinus cases, he made 135 cultures from the sinuses. In 37 instances a pure culture of bacteria was found, mixed cultures were found in 98 instances, and the strep-

tococcus viridans was found associated with other bacteria in thirty-nine cases.

Tillotson made cytologic examinations of the sinus contents and claimed the advantages over the return flow irrigations are manifold, the most important is the certainty of getting uncontaminated secretions.

Our knowledge of sinus pathology has been greatly enhanced of late. Eggston gives three terminal stages for chronic sinusitis: (1) hypertrophic, (2) atrophic, (3) combination of both. Hypertrophic sinusitis is the most common. There is an increased thickness of the epithelial layers with some infiltration of lymphocytes. The stroma shows edema with marked infiltration of lymphocytes and plasma cells. Marked cellular reaction is seen in the walls of veins and lymph channels and in the immediately adjacent stroma. The partial or complete vessel obstruction interferes with drainage. The turgescence of tissues continues into polypoid masses.

Weille reported 160 specimens of allergic tissues from nose and sinuses and found that the thickened linings so frequently reported in the antrums of patients having asthma or vasomotor rhinitis, on the basis of the present study offers about one chance in nine of harboring pus pockets, and therefore of itself being a focus of infection.

Improvement in X-ray technic and the use of radiopaque oils have tended to facilitate sinus diagnosis. Every radiologist seems to prefer his own position and technic. Iodized oil instilled according to Proetz or injected often aids in the interpretation and gives definite knowledge of the emptying time of the sinus. From this, much pathologic knowledge has been gained. Mullin thinks skilled roentgenologists can determine as much from well taken films without lipiodol.

The sinuses, as a contributing factor in disease of the optic nerve, has been reported by many. Although it is not always possible to make a definite diagnosis of sinus disease in many cases of visual loss, many surgeons believe that radical exenteration of the spheno-ethmoid region is necessary. The results reported by many seem to justify this radical procedure.

Much knowledge of general and local immunity has been added by Besredka's work. Besredka proposes a modification in the preparation of vaccine and gives a radically new method of administering it. The organisms commonly found in respiratory infections have low antigenic value, and so far have not materially improved our results but offer possibilities. The direct application of Besredka's antivirus has been tried by many including the author.

Ultraviolet is being used in the treatment of sinusitis; both general and local radiation have been tried and it is the consensus of opinion that whatever benefit is derived, comes from the general tonic effect rather than local. It is believed that overexposure with resulting thick skin is not good.

Much has been written about the sinuses in their relation to asthma. The reflex pathology from the nasal chambers to the lungs has been definitely established. Many cases of asthma have been relieved by sinus therapy, but until the cause of asthma is definitely known, and more scientific work done, one can only hope that sinus treatment will help some of our cases.

Fox studied the effect of drugs on the mucous membrane of the nose, and concluded that methol in low dilution, causes degenerative changes in the rabbit; eucalyptol and liquid petroleum produce deleterious effects; in spite of this knowledge, these drugs are used just as frequently.

The treatment of juvenile sinusitis is becoming more conservative. General and local measures to improve the patient's welfare and control pain, ventilation and drainage of the sinuses by the use of shrinkage, suction and packs, seem to be the most useful. The displacement irrigation of Proetz in combination with Bezredka's antivirus, bids fair to occupy an important place. The humidifier, diathermy, ionization, ultraviolet, iodine powder insufflation, are all important adjuncts that may be tried before conservative and later radical surgery are used.

The results of studies in general and local immunity should ultimately be of great aid.

Since juvenile sinusitis is more prevalent today and since it so frequently results from common colds, the author urges physicians to recognize this entity and refer their cases for early investigation before damage is done.

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DISCUSSION

Dr. Joseph W. Taylor, Tampa:

There may be an increase of sinus trouble in children, but it seems to me that I have seen children with discharging noses since I can remember. If there is an increase, several factors may be taken into consideration: first, we are removing more tonsils and adenoids in infants and young children than in the past. We do not know just what function this excess of lymphoid tissue has, but do know that in a great number of cases that nature tries to compensate for its removal by an excess of lymphoid tissue in the pharynx and naso-pharynx. I should like to add at this point that I believe too many tonsils and adenoids are removed in infancy and early childhood. Another factor that may account for an increase is, we are more urban than in the past, living in cities where the air is less pure, more crowded living quarters, steam heat, less light and air. All of these tend towards acute colds and every cold if prolonged means at least temporary sinus infection. I have observed in our city where we have a large Latin population that sinus infection is much more common among them. They have large families, as a rule, and live in crowded quarters. I believe this to be more a factor with them than their diet. Last but not least, I believe there is too much nasal medication in the way of sprays, drops, etc. Radiograms of the sinuses have increased greatly in the past, and that in itself may account for at least an apparent increase.

As to what takes place after a radical antrum operation, there are two schools: one claims it regenerates with the same type of epithelium as before operation; the other side claims the sinus is relieved with hyperplastic tissue. The latter has been my experience in the cases that I have reoperated upon.

I am sorry the essayist did not spend more time on treatment. I do not think any child under twelve or, better still, fourteen years of age, should have an external radical maxillary operation. Just what effect it will have on the permanent teeth in after-life, we do not know. Usually a severe case, acute or chronic, will clear up if a nasal window is done. But before any surgical interference, local treatment should be tried and, more important still, measures that will build up the child's general condition, such as plenty of fresh air, exercise and proper food. A child has great recuperative powers and, if given half a chance, will get well.

Dr. Wm. McKibben, Miami:

The incidence of sinusitis in asthmatic children, as in normal children, is much higher than ordinarily believed. The frontal sinuses, owing to lack of development before seven or eight years, are not the offending ones in infancy and childhood as are the ethmoid cells and maxillary antra; with resulting, chronic, unilateral nasal discharge with arthritis and asthma through protein sensitization.

It has been my experience that there have been more boys affected than girls. About one-third of the total number of my cases were infants. About fifteen per cent gave negative skin reactions and nearly fifty per cent had sinus infections as demonstrated by X-ray examinations. Conservative treatment having failed, puncture and irrigations should be performed, but are rarely needed.

Dr. M. H. Stuart, St. Petersburg:

I certainly enjoyed Dr. Lischkoff's paper very much. I also endorse what Dr. Taylor says about the use of drops and oils in the nose—that is, the abuse of them. I have advocated for many years when a patient has a cold to wash out the nose with a solution of boric acid and epinephrin, very weak, not enough epinephrin to cause a secondary reaction. When the nasal mucosa swells it creates pressure on the middle turbinates and closes the ostia of the sinuses. Now, if we keep these open so as to enable nature to carry on a normal circulation we are helping very much to rid the nose of any pathology. I have also in many cases, when acute ear troubles have arisen, put drops in the nose and relieved the ear trouble very promptly. I believe when we have acute rhinitis or many infectious diseases, such as measles, scarlet fever, etc., that a judicious use of drops in the nose is wise. But, if these drops are not put in correctly they do no good. The head should be almost completely upside down, held off the edge of the bed, and drops so placed that they will reach not only the lower turbinate bones but also the middle turbinates. If they do not reach the middle turbinates they will do very little good.

Dr. M. A. Lischkoff, Pensacola (closing):

I want to thank the gentlemen for their discussions. I agree with Dr. Taylor as to the indiscriminate tonsil and adenoid operation, and

have often said that tonsils should not be removed in children under three years of age, unless there is a very definite indication. Until we know more about the function of the tonsil, I think we should hesitate to remove indiscriminately enlarged tonsils causing no pathology.

About the removal and regeneration of mucous membrane after an antral operation, there is a difference in opinion. All do not agree that the mucous membrane will regenerate; Dr. Jos. Beck recently stated it only regenerates when you do not get it all out. That might be true, but how do you know that you have actually cleaned out the entire sinus? Men who have experimented with animals are convinced that the mucous membrane will regenerate after it has been entirely removed.

About puncturing the antrum, I would say that before we knew about ciliary activity or drainage, we punctured the antrum more than we should have. Hilding has recently proved that the ciliary activity tends to carry the secretions in the sinus toward the natural ostium which is high above the floor. The antrum floor is lower than the floor of the nose in adults, but as the skull develops, the antrum comes down. We usually make an opening in the inferior meatus, a Douglas puncture, and always thought that was the proper procedure. It is being done today. But according to Hilding of Rochester, the epithelium lining the sinus drains by the wavelike action of the cilia which carries the secretions up toward the natural ostium. If that be true, we should try to irrigate the antrum through its natural opening, and not make an artificial opening, or not leave that artificial opening in the inferior meatus any longer than necessary.

In regard to the use of radio opaque oils in children: my experience is very limited. I think an X-ray picture can be properly interpreted without radio opaque oils; yet I think there are times when we need to use them to aid in diagnosis, and they certainly do help to give you the emptying time of the sinus. A sinus that empties normally would be less likely to be pathologic.

In regard to treatment: Everybody agrees that conservative treatment is the best; we are making progress in conservative treatment and trying to avoid the radical operation. By the use of hypertonic solutions in the nose, by shrinking up the mucous membranes and using suction, gross and minute, we believe that we can accomplish much more than the men who used to operate on all of these cases.

URINARY OBSTRUCTION, RECOGNITION OF ITS CAUSE AND RELIEF*

GIDEON TIMBERLAKE, M.D., F.A.C.S.,
St. Petersburg.

I.

There is hardly a physician, either in or out of active practice, who is not conversant with the fact that neither males nor females, regardless of age, are immune to certain urinary disturbances. It is just as plain that, aside from functional and pathological disorders, sudden thermal changes, as from heat to cold, generally influence the urinary output. Under conditions of cold, the skin, which may be regarded as the third kidney, through which enormous elimination takes place, does not so function. Without any scientific knowledge of this, patients have a very fair idea what it is all about and, for that reason, many of them, especially the older ones, seek warmer climates during winters and migrate to one of the wonder-lands, Florida, for either conservation or recovery of their health.

Inasmuch as many of the visitors are in advanced age, climatic conditions such as are afforded in Florida permit them to enjoy their being out of doors at play in the sunshine, while such resistance as they have is maintained or whipped up by the same processes. At all events, many of them will suffer urinary disturbances, regardless. Of these, urinary obstruction seems to hold the most prominent place while the least show of blood seems to provoke the greatest mental confusion and bewilderment. In this connection, it must not be surmised that prostatics, alone, are in the picture, even though this seems to be an undesirable legacy for older men who must look upon this hazard with grave forebodings. Their apprehensions seem about as severe, in effect, as the disease. Whatever the trouble, it is the general practitioner who is first called to render service.

II.

Of the exogenic causes for urinary retention we must first consult the central nervous system—cerebral or spinal cord lesions, whether they be due to trauma, infections, tumor or hemorrhage. In this connection, I wish to serve a timely warning: when a patient, of whatever age, shows evidence of a sudden onset and paralysis of the lower extremeties to be followed by urinary re-

*Read before the 59th Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

tention, it may be well to remember that there is, most probably, a subdural hemorrhage in the lower spinal cord area. This does not require any consultation and serious brow-knitting, but the patient should be hastened to a competent neurosurgeon for a diagnosis and decompression, and there is reasonable assurance of return to health. Any attack upon this area, whether by disease or injury, as in hemorrhage, makes for enervation of the detrusor muscles for expulsion and leaves a passive bladder. In tabes, we find the vesical orifice well dilated, and so for injuries of the cord.

III.

Of the superficial lesions affecting the outflow, one is a very small congenital urinary meatus, or one that has become contracted from disease, chancroid especially; paraphimosis, or a tightened and strangulated prepuce behind the glands. Both of these are easily recognized and corrected.

IV.

Of the endogenic causes, starting from the urinary meatus, first come the acute inflammations where the Neisser diplococcus holds high rank. This obtains whether there be an anterior or total urethritis. Next, no doubt, are those acquired from employment of severely acting drugs—a chemical urethritis. Periurethral abscesses and intraurethral chancres are to be found in the pendulous urethra, while urethral tumors seem limited to the prostatic portion. Cowperitis and ischio-rectal abscesses are outstanding causes for obstruction, as in acute prostatitis and prostatic abscesses. Recognition of these three are by history, observation, and palpation. Abscess of Cowper's glands, which lie either between or anterior to the anterior layer of the triangular ligament, may be palpated bi-digitally with forefinger in rectum and thumb on outside. Both are drained extraurethrally. Each affords the general symptoms of pain, chills, fevers, sweats along with the usual symptoms of urinary obstruction.

If nature does not play its part by making for rupture and evacuation, they then come for surgical intervention. At this juncture we must stress one point: never incise a periurethral abscess of the pendulous urethra on the posterior surface unless it is "pointing," nor perform an external urethrotomy under any conditions—if you wish them to heal. The phallus is entirely too fickle and unstable a member!

Prostatic abscesses are most often caused by the gonococcus, colon bacillus and staphylococcus. Nature's method of drainage is, in order, rupture into the prostatic urethra, rectum, bladder or prevesical space through the anterior commissure. The last is dangerous unless it is recognized early so that incision and drainage can be established. If nature fails, then I either pass a blunt-nose sound into prostatic urethra and turn tip into prostate with finger in rectum as a guide; or find some fluctuating area by palpating finger in rectum, introduce Brinkerhoff proctoscope to rectum and incise. This should not be done unless there is reasonable assurance that adhesions have taken place between prostatic capsule and the rectum. If I attack this abscess through perineum, a lateral oblique, rather than a median incision is made, the finger finding the prostatic capsule when a Kelly clamp is thrust through, dilated and drainage provided. These cases usually resolve quickly, but the acute symptoms of distress hasten their absence. I have seen many prostatic abscesses opened without such design when instruments have been passed for relief of urinary retention. This, of course, is due to rupture of the floor of the prostatic urethra. None of the radical measures should be employed until a fair chance has been given by hot or cold rectal irrigations—or diathermy.

V.

Of the chronic conditions found in the female, the lacerated perinei, where the anterior vaginal wall has ceased to support the bladder floor which makes for cystoceles, residual urine, and, of necessity, low-grade cystitis seem outstanding. Repair of the perineum and cystocele usually takes care of this condition. While caruncles are the cause of very painful micturition, delay in the effort is due to psychic inhibition from fear of pain.

Of the chronic conditions in the urethra that cause obstruction, it is the stricture, either congenital, traumatic or inflammatory that comprise the triumvirate of offenders. Though congenital strictures are most rare, I have seen, diagnosed and treated them. They are early recognized, and not until intravenous urography got aboard did we find what had happened to the kidneys, which is usually double hydronephrosis. Traumatic stricture is the very worst to deal with because of its irregularity, length and density. While the first two are usually single, the inflam-

matory strictures may be single or multiple. One of the wickedest and exceedingly difficult strictures to deal with is that accruing from undilated urethrae following suprapubic prostatectomies, and lies about the prostatic urethra and bladder neck. In any event, the diagnosis and treatment for all are about alike. All of the patients complain of small stream or dribbling as well as getting progressively worse. Some find themselves subjected to complete retention, while others suffer from incontinence. Many seem to boast their forked or twisted streams.

Diagnosis depends upon history and instrumentation. The sound and bouge a boule—which is employed for both location and calibration—as well as offering some line of attack. We come, then, to filiforms and followers, tunnel sound over whalebone filiform, large sounds and Kollman dilator. Should gradual dilatation seem impossible, internal urethrotomy with the Maisonneueve urethrotome, which only divides the strictured areas, should be followed by high dilatation with Kollman dilator or large sounds. Following this, a large soft rubber catheter is introduced and fixed in place to control hemorrhage and sustain dilatation. It should be remembered, in this connection, that no force should be used in instrumentation and that tactile acuity does not functionate beyond the first constriction and danger of false passages is great if much force is made. Strictures may be palpated on sound if they lie in the pendulous urethra. It is most seldom that I resort to external urethrotomy. Filiforms, followers and patience are often rewarded. Impacted urethral calculi may simulate stricture except for attempted migration with considerable pain. If in front, they should be milked forward or moved through endoscope: if in deep urethra, they should be shoved back into bladder with nose of large sound. If tumors lie about the bladder neck and obstruct, they should be fulgurated out of the way and accumulation of blood clots from any cause, evacuated. None of this should be attempted without greatest pains at asepsis.

VI.

As an obstructing agency to urination, the prostate gland holds its own peculiar place about the bladder neck to manifest itself, physically, in many bizarre fashions. For a simple racemose gland, it seems capable of almost anything. Whether due to inflammations acquired by the younger gentry or benign enlargement in the innocent aged, it carries on. It has been my contention for years that those having suffered from prostatitis in earlier life rarely show marked evidence of great enlargement of gland in later years. Lower has demonstrated this point by injection of chemicals into prostate of rats and causing fibrosis. Very occasionally the young may suffer a sarcoma of the gland, which is diagnosed post-operatively, and is just sufficiently rare to provoke great brochures among the surgical monstrosities that literature seems so cluttered with.

The small "median bar," a piece of benign or inflammatory tissue extending between the upper prostatic poles about the vesical orifice, has not only been a grave offender but has been given vast publicity. Another is the fibrotic prostate, one that is small, firm and, betimes, regarded as an interstitial prostatitis. Benign hypertrophy superimposing carcinoma is not so rare, and diffused carcinoma is difficult to mistake, even by rectal palpation. It is referred to as being of "stony hardness." Differing from chronic prostatitis, as relates to morphology of the prostatic urethra, which seems somewhat of a cul de sac, and the similar area in benign hypertrophy showing a pronounced cul de sac, the prostatic urethra in diffused carcinoma is contracted and strictured throughout—which makes it difficult or almost impossible to introduce curve-beaked instruments to bladder. Occasionally we find prostatic calculi resulting from infection. These cause plenty urinary symptoms and pain. Diagnosis is by palpation and X-ray. Treatment is surgical evacuation.

VII.

Benign hypertrophy of the prostate may first manifest itself by exudation of blood, and followed by obstruction or retarded flow. The picture should be regarded, in order, as: urgency, frequency, hesitancy, dribbling, pain—and blood. Blood is early in benign conditions and very late in cancer. Nightly urinations are frequent and become more frequent, whereas the daily voidings are about normal. Diagnosis is completed in these, as in all other vesical neck obstructions, by history, rectal examination of gland and cystoscopies. Some hasten to X-ray but I do not find it the least necessary.

We are brought now to the dangers of permitting chronic conditions to become more chronic. The first effect is upon the general system through

discomfort, loss of rest and intoxication. It reflects itself to the kidneys, either retarding elimination of nitrogenous products, inciting infection, and possibly suppression. Too, these greatly influence the cardio-respiratory system whereby patients become worse operative risks. Acute retentions, unrelieved, may make for rupture of bladder and extravasation.

VIII.

Inasmuch as the general practitioner gets the first call to see patients with acute retention, decompression and relief is desired with greatest ease and the very least risk. In any case, there should be no semblance of speed except in the sense of getting on the scene promptly. I would suggest, therefore, that the patient be instructed to get into a tub of very warm water, pending arrival of the physician. Upon arrival, the physician should first give a hypodermic injection of morphine and atropine. This done, a small and large rubber catheter along with a large metal one should be boiled. While this is going on the field of operation should be carefully cleansed and a sponge holding some antiseptic solution placed over the glans and meatus. It is then the duty of the physician to carefully cleanse his own hands and, where possible, with a sterile syringe inject a solution of 4% novocaine or 1-500 nupercaine into the urethra to be retained for a while. Sterile mineral oil or some antiseptic jelly should be used to aid introduction of instruments for withdrawing fluid, which should be done slowly. It is deemed best to employ the larger instruments first. By no means use small metal instruments on account of risk in making false passages. If one is equipped with a Phillips catheter and filiforms, which every general practitioner should have in his kit, all sterilized, he may find entrance to bladder when all other measures fail. Should these efforts fail and no competent urologist is available, resort then is had to aspiration with trocar. In order to facilitate this, I usually infiltrate skin and pass needle deeper, leaving it in place for marker, then cut down through skin well into subcutaneous tissue. It is easy, then, to thrust trocar into bladder. Aspiration completed, I insert small catheter through canula and draw it out leaving catheter in bladder. After this, stitch tube securely in place and call for intelligent help.

As for relief of prostatic obstruction, I wish to register, here, my vigorous opposition to performing, or trying to, radical prostatectomies for diffused carcinoma of the gland. Rather, I suggest cystostomies and indwelling catheters. For pain, cordotomies, X-ray therapy and morphine for as long as needed. There is entirely too much grief assembled by radical measures for so little gain. After all, there should be the patient's welfare to be looked after. In any event, none of them should be attacked suprapubically.

IX.

The market is now burning with all manner of gadgets for relief of vesical neck obstructions, and there seems little doubt that some of them must take their permanent place in the picture to not only give relief, but to do away with a vast number of radical measures. Nor must it be understood that transurethral prostatotomies or loop resections will completely supplant them. From Young's original punch, a cautery improvment by Caulk, the Colling's electrotome, the excellent method of Bumpus and the Stern method of loop resection, which has been so generously exploited by Davis, we now come to the McCarthy set-up with current provided and regulated by the Comprex Oscillator. Yet, none of them is so efficient as to force all radical measures out of the scheme.

Any patient has left to him the choice of a suprapubic or perineal prostatectomy, whether done in one or four stages. The first stage always begins with drainage. Nehf, as does Keyes, uses four stages and both report excellent results. For my own part, whether I elect the upper or lower routes, I depend very largely upon the whole physical set-up, this to be supplemented with knowledge of the hemoglobin, clotting time, kidney function and blood chemistry. By the last I refer to urea nitrogen, creatinin and blood sugar. I have used the Young, Caulk, Collings and McCarthy methods for transurethral resection and have seen the Stern method in action. All seem to serve best in the hands of those who work most with any one of them.

There can be hardly any doubt that patients, when consulted, and informed as to what can be accomplished by the transurethral method, will prefer it even though it has to be repeated. The fact of discomfort and hospitalization limited to a few days, resumption of function and negligible mortality rate rather directs the choice. One must go to pains to see to it that his patients are carefully prepared, though many can be resected

transurethrally who could not possibly stand any open operation. They are done under caudal or spinal anesthesias.

My preference is the McCarthy instrument because it has a bakelite non-conducting sheath, completely open at end and, with foroblique telescope one is looking almost directly at the area he attacks. The loop is larger and wider than the Stern instrument; many slivers can be either washed out or withdrawn with special forceps. Through this sheath, differing from others, a hemostatic bag may be sent and drawn taut about vesical orifice to be later withdrawn through urethra. Fortunately, however, almost all bleeding points can be stopped before withdrawing instrument. In the use of this instrument, I have failed and have had to repeat, but the patients have suffered inappreciably from it.

In conclusion, I would caution all those who deal with obstructive cases to use the greatest possible cleanliness and gentleness. Both inspire confidence, make for cooperation, diminish trauma and keep infection to a minimum.

DISCUSSION

Dr. Eugene G. Peck, Ocala:

I want to say in the beginning that all cases which come under my care are referred to a specialist as soon as possible. I want to urge, though, a careful study and early diagnosis.

In all cases sent in to our hospital, my first desire is to relieve my patient. Second, I take up the consideration of treatment, after making the diagnosis in cases of retention of urine. I feel that a great many of these cases are handled carelessly by doctors during the first catheterization or emptying of the bladder, thereby necessitating extensive treatment which would not be required if we would be more careful in our first emptying of the bladder. We frequently have these patients brought in when some one has tried to use a metal catheter. We have even had one case where a doctor had punctured through into the man's rectum. He had worked on him four or five hours and the patient was practically exhausted, when admitted to the hospital. The main thing I want to call to your attention is the careful catheterization or careful emptying of the distended bladder when these patients first come under our care.

I wish to thank Dr. Timberlake for this subject which he has brought before us.

Dr. F. H. Langley, St. Petersburg:

It has been my privilege for the last three years to see practically all of Dr. Timberlake's operative work, and I have been particularly interested in the surgical application of these principles. The main thing that strikes me is his numerous methods of procedure toward relief of urinary obstruction from prostatic hypertrophy. The fact that there are various methods does not necessarily mean that any one is satisfactory in all cases, merely that the conditions vary in the different patients and that it is well to choose the particular method which is most helpful for the given individual. Thus, some cases seem to call for the Young's punch and in others a transurethral resection can be done. Particularly when a prostatectomy is advisable one has to think whether a perineal or suprapubic approach is best. The mortality figures grow very considerably if other than the best approach is used. Then, the newer method which he has described that is, the transurethral prostatomy with an electrical instrument for cutting growths in the prostrate, seems to be widely applicable. A large number of cases can be well treated by this method, and where it is used it is of advantage because the mortality rate is negligible. The bleeding is slight and period of hospitalization is very short.

In closing, I would like to express my appreciation for the opportunity of listening to this subject.

Dr. F. K. Herpel, West Palm Beach:

I want to express to Dr. Timberlake again my pleasure at hearing him take up this subject, having had the pleasure of hearing him take this up sixteen or eighteen years ago. Each time the one thing that comes to your attention and strikes you forcibly is his insistence on gentleness and a deliberate, well thought out plan of attack. My personal experience with Dr. Timberlake's method convinces me that if there is one thing that characterizes his work, it is that carefully thought out procedure, and above all his fundamental procedures he emphasizes, as he has in this paper, gentleness in all operative and manipulative procedures in the urinary tract.

Dr. Gideon Timberlake, St. Petersburg (concluding):

I am grateful, of course, to the doctors for their discussions.

The relief of urinary obstruction is of obvious importance. Uncleanliness, roughness and disregard for the patient's welfare should not be countenanced.

Transurethral resection or prostatotomy by electrical resection, with either the Stern or Davis loop, is highly technical. The casual operator can stumble through to relative success in performing a suprapubic prostatectomy, but not the least error can be endured in this last work. I make bold to state that at least sixty per cent of all prostatic obstructions can be successfully relieved by transurethral resection. I employ the McCarthy loop and Comprex Oscillator to provide current. This work is done under caudal anesthesia and no patient has been hospitalized for over a period of six days.

THE SYNCHRONIZER.

A Further Report on Two Aspects of Hypertension*

M. J. Myres, M.D.,
Daytona Beach.

This report embraces the following headlings:

1. Photographic evidence of improvement in the anatomical appearance of diseased hearts.
2. A law of kidney function.
3. Synchronization.
4. Measurement and a graphic solution of hypertension.
5. Summary.

Part three is the practical application of the study. A machine was constructed to correct the aberrant waves and make use of the vacuum pictured in the last report, which was tendered to the Florida Medical Association, at its fifty-seventh annual meeting held in Pensacola in 1930.

Some success was had in the treatment of hypertension. A few cases of somewhat similar forms of cardiac distress showed anatomical improvement. Dyspnea and tacchycardia improved in some of these; albumin and casts disappeared. Diminution in the area of cardiac dullness led to X-ray photography of the chest which confirmed the area of cardiac dullness elicited by percussion.

X-ray findings

An X-ray representative of each of three groups of successful application of this method of treatment of cardiac disease, and a case representative of a group in which the synchronizer fails are presented.

*For first report, see Jrnl. F. M. A., Vol. XVII, No. 5, pp. 216-221.

Cardiac dilation due to myocarditis in the state of fibrillation

Case 1. An aged male (67) had to discontinue his work because of severe dyspnea which was brought on by minimum exertion. Insomnia had appeared in the last month; he used two or three capsules of Alonal to get rest at night, and the capsules were losing their efficacy. The case was ambulant, that is, he refused to stay in bed and came to the office daily. No drugs were used in order not to confuse conclusions pertinent to the experiment. The reduction in size, as shown by the photograph, was achieved in ten days. He had a heavy trace of albumin and many casts in his urine. These symptoms were absent after the eighth visit. The writer knows of no drug having a like effect. Pulse count dropped from 120 to 68 and is almost regular.



Fig. 1, Case 1.—Myocarditis and Fibrillation.



Fig. 2, Case 1.—Showing reduction of Cardiac shadow.

Effort syndrome

Case 2. Mrs. D., 37 years old, has been under my care for seven years at frequent intervals. The pulse count was often extremely rapid and

never was less than 120, at times exceeding 140. Since treating her with the synchronizer her pulse is normal. She can take short walks and can do all her housework, which she could not do before treatment.

The X-ray pictures show no typical cardiac pathology nor can any difference be noted in the ten days' treatment. The case is believed to be one of effort syndrome. Perhaps there is right



Fig. 1, Case 2.—Effort syndrome.



Fig. 2, Case 2.—Effort syndrome.

sided pathology also. The writer is not an X-ray specialist. The X-ray evidence in this case is not conclusive.

AORTIC STENOSIS

Case 3. Mr. L., a male 59, complained of heart pain radiating down the left arm. The area of heart dullness was small. A faint systolic murmur was heard over the aortic cusps. Preliminary X-ray picture shows evidences of broadening of the aortic arch. The tension was low and the pulse was small and slow. Treatment of one week's duration made all symptoms worse. The aortic shadow broadened. The case was classified under the heading of aortic stenosis.

With rather small opportunity of observation and a minimum of suitable material as a basis, I shall, nevertheless, point out that whenever aortic stenosis is diagnosed, the synchronizer fails and patients are made clinically worse.



Fig. 1, Case 3.—Aortic stenosis.



Fig. 2, Case 3.—Aortic stenosis. Increasing dilatation is evident.

AORTIC ANEURYSM

Case 4. B. C., male negro, 51 years old. This patient was practically moribund when brought to my office; the aneurysm had existed seven years.

Owing to progressive narrowing of the esophagus, which must have passed over and become

engaged in the blood vessel tumor, he had been unable to partake of food for three weeks.

Some criticism may be had for the treating of a patient of this type at my office. However, he was doomed at all events and it was felt that the experiment, while it could not possibly cure him, might help others in not so great an extremity.

The experiment was performed in the following way: The first picture was taken; the machine was applied eight minutes; the second picture was taken. The patient was then hurried home. He swallowed some milk the next morning, an effect believed to be due to the dramatic suggestion of the event.

However, the X-ray evidence justifies the application of the method in similar cases. Had I had hospital affiliation, further treatment with the machine would have been justifiable. The negro starved for another four days; rectal alimentation failing altogether. It was a case that tempted me to continue the treatment, yet it was felt that in a small town, a medical reputation could not defend a death from such treatment if given in an office.



FIG. 1, CASE 4.—Aneurysm.



FIG. 2, CASE 4.—Aneurysm. Administration in size is evident.

II. LAW OF KIDNEY FUNCTION

Experimental and clinical evidence show that kidney function is subjected to the law

$$\frac{dw}{dy} = f.$$

w, work; y, path; f, force.

This means that the direction of force is the governing feature regulating kidney secretion. Derivation of this law will be relegated to the section of measurements. The influence of the path of action on kidney secretion can be followed by:

1. The quantity of urinary secretion.
2. Chemical composition of the urine.
3. Specific gravity of the urine.
4. Specific gravity of the blood.
5. *Tension of the arteries.*

The clinical proof of this law is found in the well-known fact that diseased kidneys function excessively when the patient lies down. Familiar symptom entities are:

1. Enuresis of childhood.
2. Nocturnal frequency of micturition of cardio renal disease.
3. A few cases of early pregnancy whom I have examined in this respect, follow the law to an extreme. This observation may, I hope, lead to the diagnosis of early pregnancy if carried on by other investigators.
4. Success of the experiments with the machine designed to change the momentum are apriori evidence of the function.

In order that the next section seem not too remote from common clinical experience, a sequence of events leading to bed wetting is examined.

The kidney secretes a certain quantity of urine all day long. The child is led to urinate before retiring. However, as soon as it lies down, the path of the momentum is changed, let us say, from a vertical to a horizontal one. Coincident with this change an increase in secretion of urine takes place with unfortunate consequences.

Momentum presents for examination force, time, mass, velocity, distance and kinetic en-

ergy which function together in the relation

$Ft = mv - mu$, $Fs = \frac{1}{2} mv^2 - \frac{1}{2} mu^2$,

s, distance.

The synchronizer is designed to vary and adjust these entities.

CHANGE OF FORCE

Two methods to produce the desired change of force were examined and used when the machine was designed:

1st. Change of Force by impact.

2nd. Change of Force by refraction.

Consider two ivory balls suspended by fine strings at equal heights. If the first ball, or the batter, is pulled back a certain distance and allowed to hit the object ball (2), it, the object ball, will fly off a distance equal to the force of impact. If there are three balls engaged in the experiment, the object ball (2) remains at rest while ball three flies off and takes up the force of the impact. Call the batting ball (1), the pulse; the middle ball (2), the arterial wall and ball three the elastic cushion of the synchronizer. If the elasticity of the air cushion just equals the pulse strength, the arterial wall is robbed of the vibration produced by the force of the heart beat, and this mechanical feature is used in the reduction of the hypertension.

Refraction[1] is best observed if the waves along a shallow beach be studied. If water (or pulse waves) strike an obstruction which sets out into a channel vertically, they are reflected vertically. If they approach the vertical wall at an angle they flow back at *an equal angle*. (The sine angle of incidence is equal to the sine angle of refraction.) But if the shore be a shelving one, they slowly turn so as to be parallel to the shore, and flow up on it with diminished vigor.

The speed of the current along shore is increased by this maneuver; it is the undertow, in the parlance of the beaches. The necessary condition to produce refraction is a shelving obstruction made of material which is not penetrated by the wave.

SYNCHRONIZATION OR TIMING

Explanation of how to time the heart is made difficult when the subject must be compressed to the limits of a paper which will not bore its readers. Measurement of velocity, wave length, and weight resulted in simple formulas. These were checked sufficiently, it is believed. The user can read them from the flow chart with about the same confidence given any clinical method of physical diagnosis.

I regret exceedingly not to be able to digest the knowledge of wave analysis necessary for the use of the machine to the dimensions of the paragraph allotted to each subject. Suffice it to say that in the control of the heart time the wave length is the length of the brachial jet, and computations and the flow chart coincide with this statement. I shall content myself with advising the reader to take this quantity from actual measurement, rather than fudge an explanation of wave analysis. No excuse is made for seeming meticulousness in this regard. Just as the repair and timing of a valuable watch or automobile is not entrusted to careless hands, care and some planning must precede the use of the method. The method would soon be brought into disrepute were the machine placed in the hands of and exploited by every "physical" fakir and just be allowed to percolate. The subject so neglected will, therefore, receive attention in a special paper. The machine is very exact. It will only put out whatever you set it to do. It can be set to control the wave lengths of circulating blood to an excessive degree of exactness.

SYNCHRONIZATION BY WEIGHT

Synchronization by weight is possible only when the source of energy is periodic. Pressure due to a non-pulsating current would not be changed by adding a weight. What the weight does is to lessen the number of times the heart pumps and among other functions changes the phase of the vibration. This allows the heart to push against the column of blood to better purpose. The lessened number of more efficient beats gives this long suffering organ the rest it seeks.

The mechanism works much as does an automobile running up hill. When the spark is retarded, stronger explosions, slower in time, save the engine from wear and knocking. Some cases are not benefited but are hurt by the procedure.

SYNCHRONIZATION BY MECHANICAL BARRIER

In high blood pressure a disturbance of timing causes such symptoms as Cheyne Stokes[2] breathing and cardiac asthma. These phenomena are due to the interference of blood waves. They can be compared to a number of horses on a race course. The problem the starter has to face is to get all the horses "off" simultaneously, and he does this by aligning them at the "barrier" which is suddenly raised and the spirited animals are "off" together.

Electricians use the same procedure to reset

clocks to the zero hour in certain areas where such service is furnished. It is done by pressing a lever say at 12 o'clock; all clocks on the circuit snap back to 12 o'clock. They are then in time. It is a very necessary adjunct to the control of teletypewriters. These machines type messages sent by a master typewriter at the central news office. A tap of the key of the typewriter at the central office is only for the release of certain electrical combinations. Actual work done is performed at each typewriter by an electric motor. These motors while manufactured identically are subjected to differences in environment which are unavoidable, such as local currents, climate, etc. They are kept in time by an electric barrier which resets them at periods which are fractional portions of a minute. The changing conditions to which the electric current is subjected in its 1000 mile span is in every way similar to the flow of the blood in the arteries.

CONSUMPTION OF TIME BY IMPACT

In the paragraph which concerned itself with momentum, means of absorbing and converting force were described. These methods may also serve to convert and absorb time. When two elastic bodies meet at impact, an appreciable interval elapses in which the objects first are deformed by the force and only then move. This deformation remains in non-elastic materials such as mud, clay, lead, etc. However, when the body is perfectly elastic, calling to mind ivory, glass or rubber, time is spent in first regaining former shape and conformation before bouncing off on its predetermined path. How tension is relieved by these methods is found in the more technical chapter "measurements."

MEASUREMENTS

In order to give the paper some worth to those who are engaged in similar investigations, inclusion of a few of the technical data used will be permitted. Again, the quantities sought are necessary to the construction of the flow chart.

THE VELOCITY OF THE BLOOD IN THE BRACHIAL JET. (Fig. 1.)

MacLeod[3] deplores the fact that no simple way of estimating the velocity of the blood has been found. He refers to the stromuhr, and to the injection of colored fluids into the circulation, the return of which to the place of injection, is clocked.

The following simple procedure is brought to your attention. Whenever the cuff of the blood pressure apparatus is properly adjusted, slide the

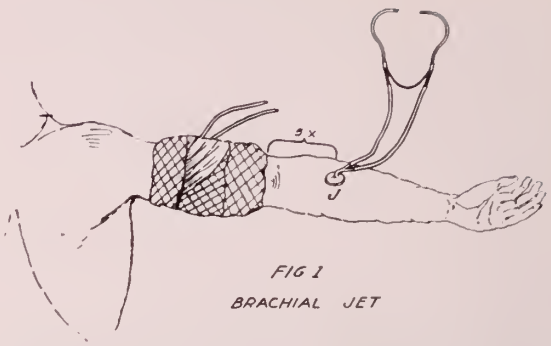
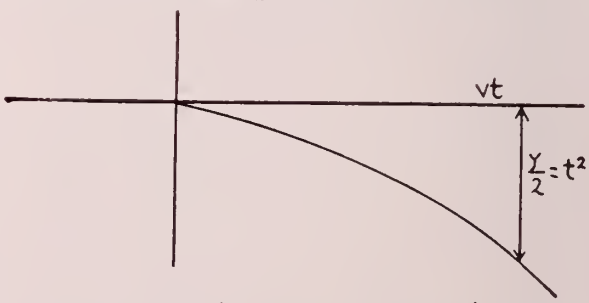


FIG 1
BRACHIAL JET

stethoscope down the arm until you no longer hear the cluck of the pulse. Measure this distance J and multiply by five. Then let us say the distance is three inches, (3x5=15). The velocity of the blood is 15 inches a second.

The reasoning underlying this deduction arises from the following: Consider a cylinder of water 20 cm. high; let us puncture it at point d, then the pressure will be d3 and the water jet will not squirt as far, nor as fast (vt 1), as it will when we puncture at d5. Here the pressure will be d4 and the velocity will be (vt2). (Fig. 2.)

In order to apply this calculation to the brachial jet, the circulation of a local negro was studied. His jet was advantageous in that the demarcation of the disappearance of the sound at the point J was a clear-cut one, a condition which is not always present. His systolic pressure was 150 and his diastolic pressure was 82. If we started at the heart and placed the gain in velocity at each beat in proper relation we see the curve to be like that of the jet from the puncture in our water cylinder. Figure 3 shows these blocks of systolic[4] and diastolic pressure in proper relation to each other. The following calculation is offered:



Let X be the horizontal and y the vertical axis. The coordinates of any point on the curve followed by the outflowing blood will

$$x - vt \text{ and } y/2 - t2$$

in which v is the velocity in feet per second. T – the number of seconds and g – 32.2, eliminating T we have

$$\frac{y = gx^2}{2v^2} = \frac{16.1x^2}{v^2}$$

Let y = 0.644 ft = 7¾ inches approximately

Then $\frac{16.1x^2}{v^2} = 0.644$ $\qquad \frac{x}{v} = 0.2$

$\frac{x^2}{v^2} = 0.04$ $\qquad v = 5x$

The velocity equals *five* times the jet.

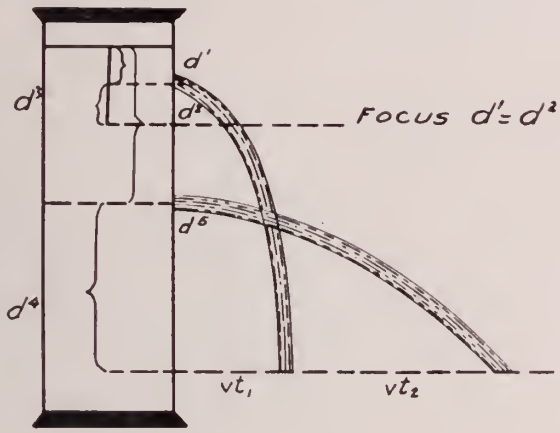


Fig. 2.

WATER JET

DERIVATION OF THE LAW OF KIDNEY FUNCTION

It is hoped that the following discussion falls into hands of clinicians better qualified than the writer to apply the logic here presented. To them this portion of the work is addressed. If the work of the kidney depends on the direction and amount of pressure, a yard stick is given into their hands to measure the clinical changes going on in the organ. The machine varies these forces accurately. All that is needed is the standardization of the dosage which only experienced clinicians can supply. All things are not given to all men and a pleasing and interesting style is vouchsafed but to a few. Rather than try to "doll up" a lame and faltering ability in description, the subject will be presented in all its bareness, as if already dissected.

The nub of the whole subject, and the point here emphasized, is that the synchronizer can be made to control the time, the velocity, the wave length and the momentum of the circulating blood, and in this way symptomatic relief of many severe ailments can be brought about.

Proof of the statement of Sylvanus Thompson "that if force be used to produce a displacement in any direction, the force in that direction is equal to the rate at which work is being done per unit of length in that direction," is before us.

$$F = m\,a \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad (1)$$

m, mass, and a, acceleration; f, force as before. The product of mass by the speed is called momentum.

$$f = m\left(\frac{dv}{dt}\right) \quad . \quad . \quad . \quad . \quad . \quad (2)$$

v = velocity
t = time

$$\frac{d\,(mv)}{dt} \text{ or } m\left(\frac{dv}{dt}\right)$$

is the rate of change of momentum. These equations apply to instantaneous values when momentum is changing.

Let force be employed to displace a *resistant* force so that

$$w = f\,x\,y \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad (3)$$

w = work,
y = distance or path.

$$dw = f\,x\,dy \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad (4)$$

and an element of work is in relation to an element of the direction of path y,
and finally,

$$\frac{dw}{dy} = f \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad . \quad (5)$$

in which f equals

$$f = m\left(\frac{dv}{dt}\right)$$

the rate of change of momentum, which the machine is set to govern.

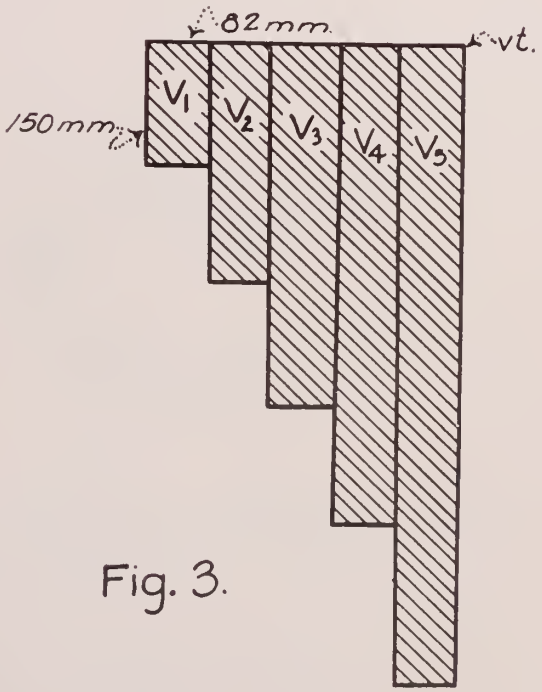
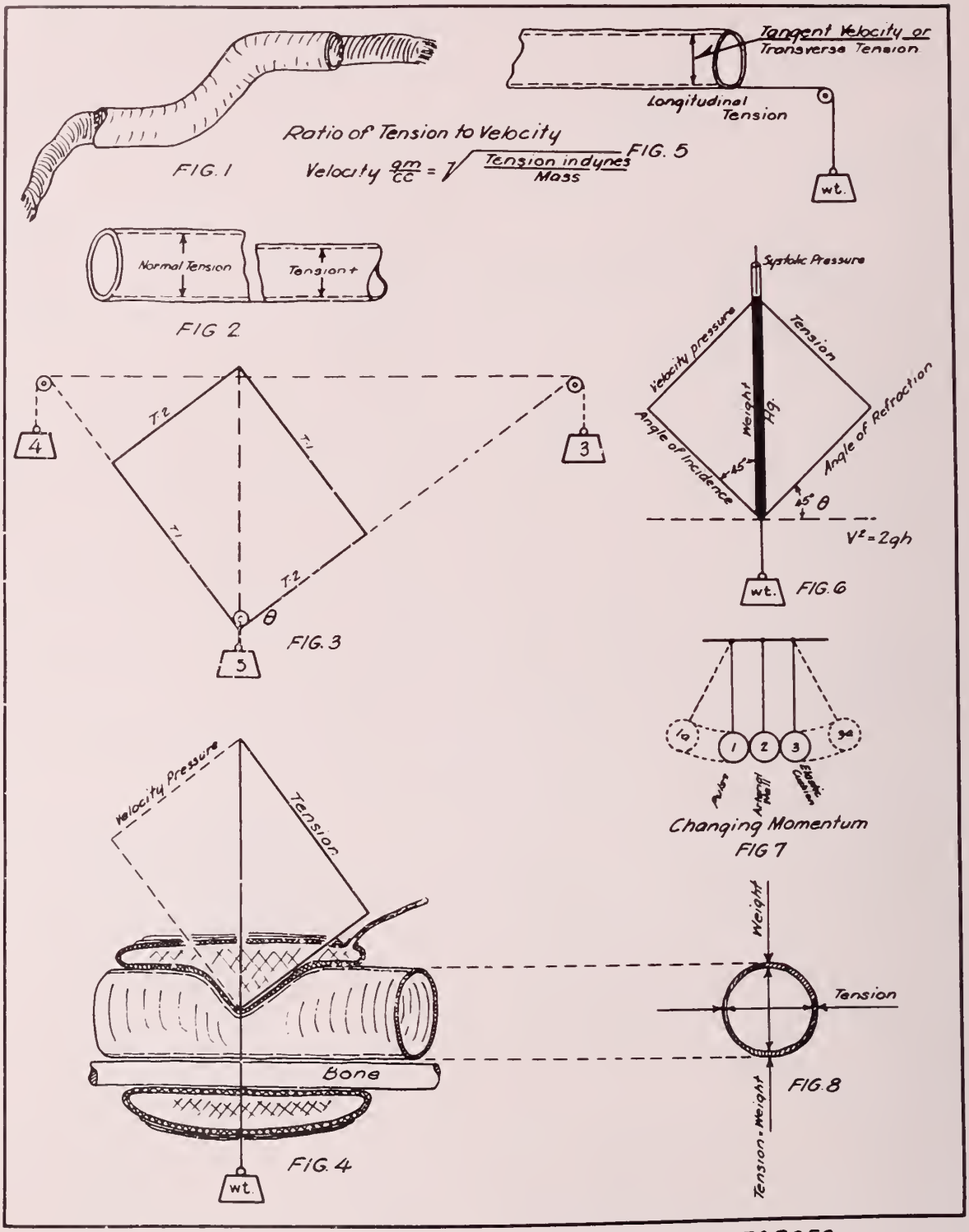


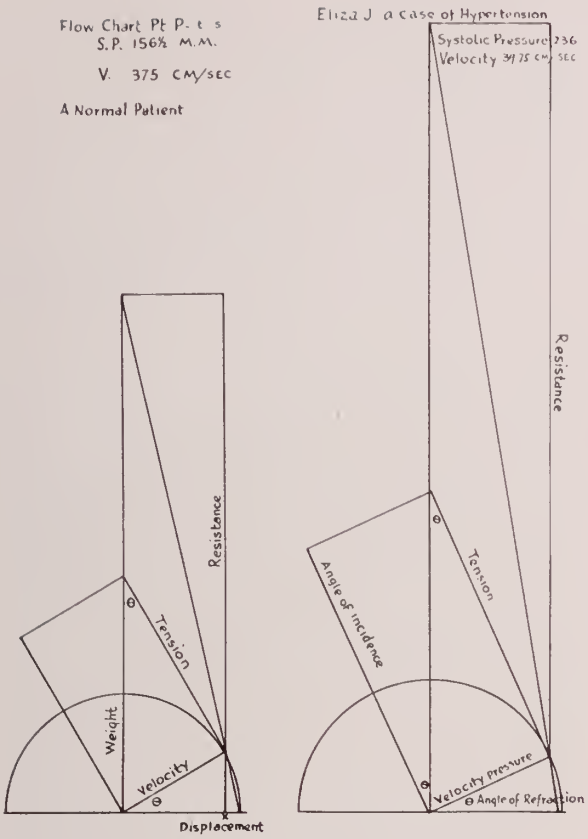
Fig. 3.

SUM OF VELOCITY



RELATION OF TENSION TO PARALLELOGRAM OF FORCES
Tension = Weight Cos. θ

FIGURE 4.



THE FLOW CHART, A GRAPHIC SOLUTION OF HYPERTENSION

It was thought that the average clinician would be slow to join in the experimental use of the method if he found it necessary to pursue a tedious calculation before setting the machine. A graphic solution of the data was planned and it is believed checked sufficiently for publication. Two measurements are necessary, the velocity, or five times the length of the brachial jet, and the systolic blood pressure, all units being in gram/cc.

The systolic pressure is marked on the vertical axis. With the velocity as a radius, an arc is struck. The foot of the arc is connected by line three with the systolic pressure, and the point of intersection is connected with origin.[5] A perpendicular tangent to this radius joins this point to the perpendicular. A line is drawn parallel to the velocity line and one parallel to the tension line, completing the parallelogram of forces.

The lines are named as are the ones in the accompanying chart. Necessary to make the chart is millimeter paper, a right angle and a blood pressure apparatus.

The justification of reading the tangent line as tension is because tension is proportionate to the tangental velocity-pressure.

Attention is directed to the forces in an artery under pressure. There is the force pushing the blood down the artery; this pulse bulges the artery out at the sides whenever the heart increases the force pressure or the blood current meets resistance. The arterial wall presses inward on the blood with just the same pressure as the blood stream pushes it out. Should it relax or burst, an aneurysm or a rupture occurs. Or we may say if the amount of the constricting force be a little bit less than the tangental pressure a rupture occurs. If the constricting force exceeds the expanding forces, a hindrance to the flow is caused and a rise of pressure takes place. Knowing that the sum of the expanding forces is on a line perpendicular to the flow, the estimation of the value of tension in grams is equal to weight cosine Θ of the flow chart. Because we have two forces mutually perpendicular to each other, the resultant of necessity is equal to a side of the angle and the cosine of the included angle.

This measurement is of great value in subsequent calculations.

It is to be hoped that the chart will have clinical value in other circulatory diseases. An interne or nurse can prepare 15 or 20 of these charts in a half hour's time, the data and measurements being of great simplicity.

The chart has drawbacks. It is based on static theory and is most accurate if the posture (seated or standing) of the patient be erect. It is not thought safe to read time from it. This can be gotten more conveniently from the pulse count.

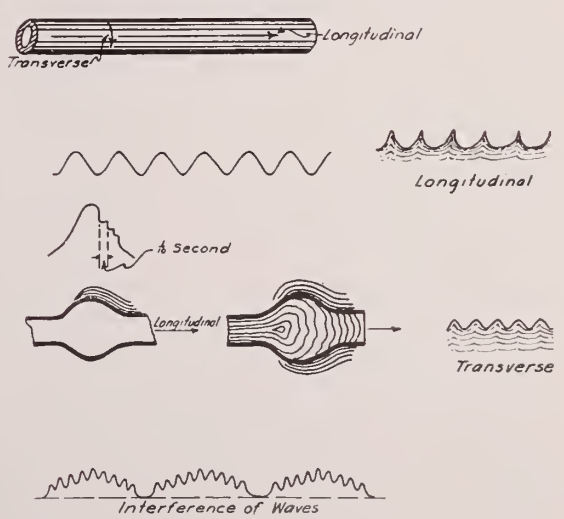
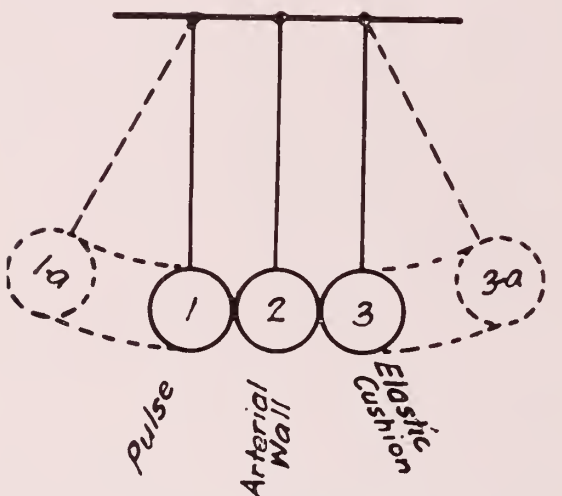


FIG. 5.—(a) Longitudinal free and (b) Transverse waves.

REDUCTION OF TENSION

The accompanying drawings (Tension Chart) show two sets of waves which concern the therapeutist, a longitudinal free one which courses down the artery representing the systole of the heart. As it passes through the artery it sets up transverse waves in the blood stream shown in figure 5. A third set of waves, longitudinal in direction, is present in the arterial wall. This wave has a period which when it differs markedly from that of the fundamental wave length seems either to cause or accompany high tension.

The waves travel the length of the path and return and have been identified on the return trip as "echo waves." In a previous paper it was



Changing Momentum

FIG. 7

shown that they have trigger action on a heart accelerator situated in the arteries, in the heart itself or in the nervous system.

The synchronizer starts a wave which fits (or nearly fits) between the wave lengths of the offending vibrations. With its establishment, trigger action does not occur.

The velocity usually increases after this neutralizing procedure and the blood pressure falls partly due, it is believed, to an increase in "mass movement" of the blood. The reason of the fall is thought to be due to the sum of the suction caused by the mass movement, the change in momentum and the lessened number of heart beats.

At times, the new rhythm is markedly persistent. At others, it is soon lost. The average time it continues is about six weeks. The machine is run for about 8 to 20 minutes. Its effect on patients is either unnoticed, or it acts in a way to soothe them and some sleep through the treatment. A fall of 30 to 40 millimeters of blood pressure is the usual result of the treatment even of severe and "terminal" cases of hypertension.

SUMMARY

No claims of therapeutic cure are made for the machine. The writer was taught that cure of cardiac disease lay in the reduction of the size of the heart and slowing of the pulse beat. The course of nephritis was followed by the presence, amount, and continuance of its contained albumin. Hypertension was measured by the continuance of the blood pressure. These symptoms are alleviated by the treatment so briefly outlined. The machine is presented for test because the anatomical changes shown by the X-ray are thought sufficient evidence to warrant inquiry as to whether therapeutic value exists.

In many diseases it is vain to expect a machine to remove the underlying causes of complaint, calling to mind pneumonia, heart disease due to a still active syphilis, rheumatism or other inflammations in their acute stages. Only when pressor substances have disappeared or have been neutralized can any lasting effect be expected. Nephritis, acute and chronic, are caused and continued by the same agents, so that these must first be combatted before any result can be expected.

The machine can and will arrange circulation so that the heart has least effort to put out, and it can time the circulation so that the kidney can work more efficiently. These are its limits.

My best thanks are due to Capt. H. C. Peters of the U. S. Engineering Corps and to Mr. L. M. Drake for real help and advice; also to Drs. R. L. Miller and K. West for assistance in the making of a precision blood pressure apparatus which was of great help in the work.

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SPINAL ANESTHESIA*

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Tampa.

In a certain class of patients the proper selection of the anesthetic to be used for an operation assumes a great deal of importance; often, it not only determines the immediate outcome of the surgical procedure which is undertaken but it has much to do with the post-operative course, the post-operative mortality and morbidity.

In the young and middle-aged patients who are robust and vigorous there is little question as to the immediate result, regardless of the anesthetic used. In this group, however, we must occasionally take into account the various complications and sequelae which occur, often of a minor nature, but at times of serious import and which might have been prevented by a more careful consideration of the anesthetic.

My advice is occasionally sought to decide whether or not spinal anesthesia is indicated by surgeons who have had little experience in operating under this anesthetic. Invariably these patients, if not actually moribund, are such poor risks that serious doubt is felt as to what the immediate outcome of the operation will be. It is in this group of cases that death may occur on the operating table and the death in all probability would be attributed to the anesthetic. On the other hand, in good risk cases, in the young and vigorous, in patients with an excellent cardio-vascular apparatus, these same doctors rarely give spinal anesthesia a thought or, if they do, it is only to condemn it. It is in such cases that it should be used most and, in my opinion, when we take into account the complications and sequelae which can justly be blamed on inhalation anesthesia, we shall find that spinal anesthesia is the safest and most pleasant anesthetic at our command. However, in the senile, the arterio-sclerotic, the grave cardiac case, the highly toxic patient, the nephritic, the pros and cons must be weighed carefully before we determine what anesthetic shall be used. If in this group of cases we decide that the advantages of spinal anesthesia, such as extreme relaxation, the absence of irritating and toxic effects on the lungs, liver, and kidneys and the less frequent occurrence of persistent vomiting, etc., outweigh the disadvantages, and if we are experienced in the use of spinal anesthesia, then it should be used. If we are comparatively inexperienced in its use then we had better gain our experience in the young, vigorous and robust. In this group, in an experience which concerns over 2,500 cases I have never seen any serious untoward reactions.

A few patients, especially those with a tendency to nervousness, express a desire to be unconscious during the operation; they also fear the lumbar puncture. By gaining the confidence of these patients and by carefully reassuring them of the advantages and safety of this type of anesthesia, by the careful use of pre-operative narcotics and hypnotics and by careful technic in performing the lumbar puncture such patients go into the operation perfectly tranquil and unafraid.

We have used this anesthetic in approximately 120 cases in the past twelve months and have had no occasion to regret its use despite the fact that we have refused to give it to only two cases. Supplementary anesthesia was used in only two patients; one of these was a kidney operation in which an insufficient amount of the anesthetic was given and the other was in a nervous and neurotic female who was to have a lower abdominal operation. This patient would have done better under some other type of anesthesia. One of the patients in this group had to have two injections before satisfactory anesthesia was obtained. This compares favorably with other reported statistics in which supplementary anesthesia is used in from five to twenty-five per cent of the cases.

We occasionally have had patients come to the operating room without sleeping well the previous night and who were extremely frightened. Rarely will fear alone produce such marked symptoms during the first few minutes of the operation as to cause alarm as to the patient's condition. The symptoms produced, as I have noticed them, are a rapid and weak pulse, a marked pallor and usually quite an unstable blood-pressure. These are, however, only temporary, as a rule, and if it is possible to divert the patient's mind she is soon unaware that the operation is in progress. Undoubtedly fear has played an important part in some of the untoward results which have been reported from the use of spinal anesthesia. A good night's sleep is important before any operation and it is especially important when spinal anesthesia is to be used.

*Read before the Hillsboro County Medical Society, July 5, 1932.

We now always see that the patient gets a full night's sleep using large and repeated doses of narcotics and hypnotics if necessary. I feel that the lack of sleep and the symptoms produced by the fear of operation have never been emphasized sufficiently in the literature. This fear and dread sometimes amounts to actual insanity in which the patient may commit suicide.

The problem of proper pre-operative medication is sometimes a perplexing one. If we could foretell how different patients will react to certain sedative drugs and what dosage is necessary the indications for or against spinal anesthesia would be more clearly defined. We should attempt to solve this problem in each individual case and thereby relieve the patient of nervousness, apprehension and worry and also lessen the amount of the anesthetic needed. The latter particularly applies when a general anesthetic is used and the former when regional or spinal anesthesia is selected. Unfortunately, all of our sedative drugs in dosage sufficient to produce the desired effect are depressive to some extent and this is particularly undesirable in weak, aged, poor risk cases when spinal anesthesia is used. In such cases, the least pre-operative medication used, generally speaking, the better for the patient. Nervous, apprehensive, but young and robust patients will stand large doses of the sedative drugs without untoward effects. Many of our patients, if we can insure them of a good night's sleep the evening preceding the operation, will not require any sedative drug the morning of the operation.

We used in most of our cases a combination of sodium amytal and morphine. The usual order at night is sodium amytal gr. 3, followed in an hour by morphine gr. 1/6 to 1/4 if patient is not asleep, and sodium amytal gr. 3 to gr. 6 at seven A. M. followed by morphine gr. 1/6 to gr. 1/4 at 7:30 if the operation is to be at eight. These doses are varied a great deal according to the condition of the patient. More may be used for the young and healthy and less for the weak and depressed.

Due to the protective action which the barbituates exert against any toxic action of novocaine it is particularly important to use one of these preparations when novocaine is used locally or intraspinally.

Sise has outlined three states of the effects of sedative drugs as used pre-operatively:

1. Mild sedation. Patient is conscious but is quiet and less apprehensive.

2. Mild sedation. May or may not be conscious or amnesic, but in any event he loses a certain amount of nervous control and coordination. He may give way to his fear or be simply uncooperative. Often he is difficult to manage

3. Patient deeply narcotized, quiet, relaxed, usually unconscious or at least amnesic.

The first and third stages are desirable and in the majority of instances the first is to be preferred especially when there is any question as to the operative risk.

It is noteworthy that over half of this series of cases have been patients who were considered excellent risks and undoubtedly would have stood any kind of anesthetic. All of them had an unusually smooth convalescence and without exception have become spinal anesthesia boosters. It is now not uncommon to have patients come to us and request this type of anesthesia.

SPONTANEOUS SUBARACHNOID HEMORRHAGE.

Report of Three Cases.

Henry Fuller, M.D.,
Mulberry.

Because it is not generally appreciated that spontaneous subarachnoid hemorrhage is as common as it is, it should be of some interest to report three cases occurring in the same small town in Florida, all within the past two years. The importance of the condition probably is not well recognized and it is very likely true that many subarachnoid hemorrhages escape our notices, most of them being mistaken for cerebral hemorrhages, uremia or possibly meningitis.

Case 1.—A married negro laborer, who said he was 49 but who looked older, had been in perfectly good health except for failing vision until the middle of one afternoon when, while working in the woods with a crew of prospectors, was suddenly taken with a violent headache. He remembers finding some shade under a tree and lying down. This was the last he remembered for the next five days.

The patient was missed from the prospector's camp that night and the next morning, after a search, he was found asleep on the ground near where he had been working. He could be aroused from sleep but only with difficulty. He

was brought to his home in town and was seen about twenty-four hours after the onset.

At that time, examination showed a well-developed and well-nourished negro man in semicoma. When aroused, he knew his name but was disoriented for other facts and could be kept awake only with difficulty and not for long. His temperature was 101, pulse 88, respiration 18. The pupils reacted sluggishly to light. The eyegrounds showed optic atrophy and a deep glaucomatous cup in the right eye. Left eye showed a pale pink disc but no optic cupping, at least nothing like that which was in the right eye. The veins in both fundi were obscured and definitely compressed at the arterial crossings. There were no hemorrhages or retinitis. His neck was rigidly stiff. Kernig's sign was positive. Blood pressure was 215/150. The heart showed enlargement to the left. A catheter specimen of urine showed a trace of albumin, no casts, no sugar; specific gravity, 1.012. The examination was otherwise negative.

It was thought that this was probably some sort of meningitis and a lumbar puncture was done. The fluid was under apparently increased pressure and was cloudy and reddish. A smear showed many red blood corpuscles and a few white blood corpuscles. After centrifugation the supernatant fluid was yellow. Spinal fluid Kahn was negative. A blood Kahn was also negative.

Spinal punctures were repeated daily for seven days. Manometer readings were not taken but the fluid pressure seemed to return to normal slowly. The fluid soon lost its bloody color. The xanthochromia remained. The temperature subsided after five days. From then on the patient made an uneventful recovery.

At the time of this writing—nineteen months later—the patient feels perfectly well and is up and about daily. His chief concern is his failing vision. His blood pressure remains elevated—200/150—and his urine shows a trace of albumin and a somewhat low, fixed specific gravity. He has not had any more such spells.

Case 2.—A married, American, white man, aged 61, was suddenly taken with a very severe frontal headache while hoeing in his back yard. He became dizzy and vomited soon after he got into his house. Home remedies at hand did not relieve his headache. Within a few hours he had become stuporous but did not lose consciousness.

For two years he had been in poor health. Two years previously, he had had an attack similar to the present with a terrific headache, nausea and vomiting lasting several days. He recovered from this without any paralysis but had never been strong since. His blood pressure during the former attack, and since it, had been known to have been elevated considerably.

The remainder of his history seemed to have no bearing on his present illness.

When seen the morning after the onset of the headache—about eighteen hours after it began,—the patient showed no disorientation, but he was very drowsy and his neck was definitely stiff. Kernig's sign was positive; temperature 100, pulse 72, respiration 18, blood pressure 230/145. There was well-marked cardiac enlargement to the left but no other cardiac abnormality. The retinal vessels showed evidences of arteriosclerosis of a mild degree. A specimen of urine showed a trace of albumin and a few hyaline casts but no sugar or acetone.

Lumbar puncture was done immediately. The fluid was under apparent increased pressure and was frankly bloody. Lumbar punctures were repeated daily for five days. At the second one the fluid, in addition to being pinkish, was also yellow. The red color of the fluid was absent at the latter punctures and the patient was brighter and more alert after the third tap. His temperature, however, did not return to normal. One week after the onset, the lungs showed crepitant rales at both bases. He had begun to cough a little. Another lumbar puncture showed no blood and a slightly yellowish fluid under no apparent increased pressure. There were no important neurological findings but he continued to do very badly. The pulmonary signs continued, he raised purulent, greenish sputum, his temperature ranged higher and on the thirteenth day of his illness, he died.

Case 3.—The third patient was that of a widowed, white woman, aged 70, who had been feeling perfectly well until noon of the day of onset when, while reading a paper, she suddenly complained of a very severe headache, dizziness and blindness. The headache was in the right, frontal region. In the afternon she became very drowsy, during the succeeding night and day this

drowsiness deepened almost into coma; she became very restless, was nauseated and vomited several times.

The patient had been known to have had hypertension for at least four years. She was not subject to severe headaches however. Four years previously, she had had a severe headache lasting three days with nausea and vomiting during which her blood pressure was said to have been as high as 270. Since then, she had been in excellent health. It was not known what her blood pressure usually was in the past four years.

The remainder of the history probably had no bearing on the present illness.

On examination the first day, the patient showed little to suggest a subarachnoid hemorrhage. She was well developed and nourished. Her neck was not stiff. There were no paralyses of the cranial nerves nor of her limbs; blood pressure 240/130. The heart showed very slight enlargement to the left, but no other abnormality. The lungs and abdomen seemed normal. There was no evidence of congestive heart failure. The left eye showed a mature lenticular opacity, the right an immature one. In neither eye could the retinal vessel be clearly seen because of these opacities. The urine showed a trace of albumin and a few hyaline casts. Specific gravity was 1.015; temperature, 98.6; blood non-protein. Nitrogen was 27 mgm. The temperature became a little elevated the second day and for four days ranged from 98.6 to 101.4. On the evening of the second day, her neck seemed a little stiff. The following morning it was definitely rigid. Blood pressure then was 230/125.

Lumbar puncture at this time showed a bloody and yellow fluid under increased pressure. After withdrawal of all that could be obtained without jugular compression (about 30 cc.) the patient immediately became conscious and rational and for the first time in over twenty-four hours recognized her relatives.

On the third day, the patient could not move her left arm or leg. This paralysis had not been present before and it naturally raised the question of a cerebral hemorrhage. The lumbar punctures were repeated, however. By the second puncture the pressure had dropped to normal and the bloody color had disappeared, the yellowness of the fluid remaining. Three days after the first puncture the weakness of the left side had vanished.

Twenty-four hours after the first puncture, the blood pressure was 175/100. Taken twice daily thereafter for a week it has never been above 220/120 and has usually been nearer 200/100. Only three lumbar punctures were done.

Today, nine days after the onset, the patient feels perfectly well in every respect.

Comment.—Three cases of spontaneous subarachnoid hemorrhage are presented and while nothing new is added to the symptomatology or treatment of this syndrome, it is felt that this presentation is worth while if for nothing more than to place emphasis on the condition. All three cases occurred in persons over 49, all with chronic nephritis with hypertension. Each case presented the classical symptoms and signs as described by Richardson,[1] Ohler and Hurwitz,[2] and Armour,[3] namely: sudden onset of headache, drowsiness, stiff neck and bloody spinal fluid under increased pressure.

There is only one comment to make concerning treatment. The essential treatment consisted of lumbar punctures. In addition hypertonic solutions given intravenously and per rectum. Caffeine sodiobenzoate under the skin in 7½ grain doses could have been given and the patient could have been propped up in bed. The last two procedures have been shown by Kennedy and Wortis[4] to lower considerably the intracranial pressure when it is elevated. None of these latter procedures was carried out in these cases as it was felt that the pressure was being adequately lowered in each case.

Two patients of the three cases presented here recovered. One died. It was felt that bronchopneumonia was a contributory factor in the one death. The paresis of one side of the body in one case is interesting and might have meant that the hemorrhage occurred in the meninges near the motor areas for the left arm and leg.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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BRONCHIECTASIS

It is not generally known that bronchiectasis is one of the most common pulmonary infections, ranking close to pulmonary tuberculosis. Bronchiectasis often masquerades as pulmonary tuberculosis and a considerable number of the patients in tuberculosis sanitaria have this disease.

A dilatation of the bronchi, either fusiform or saccular, is always present. There is a difference of opinion as to etiology. Bronchiectasis may be congenital, obstructive or associated with pulmonary tuberculosis. Chevalier Jackson has shown that many cases are caused by foreign

bodies. Hedblom also believes that many acquired cases are due to obstruction. Ochsner believes that many cases are the result of a recurrent or mild grade infection of the bronchial tree. It is usually associated with infection of the upper respiratory tract, sinusitis playing an important role.

The diagnosis of early bronchiectasis is not easy. It should be suspected when there is a history of sinusitis with repeated attacks of coughing. Loss of weight and malaise may be the only symptoms. Hemoptysis occurs as often as it does in pulmonary tuberculosis. Bronchography or X-ray visualization of the bronchial tree by the introduction of lipiodol is the best method of making a diagnosis. The technic is simple. Ochsner applies a 10 per cent solution of cocain to the anterior pillars of the fauces thereby abolishing the swallowing reflex and allowing the lipiodol to run directly into the trachea and bronchi. Lipiodol is non-irritating; liberates iodine slowly and acts as an antiseptic. The oil sinks so that the secretions float on top and the patient can better empty the cavities. Because of this benificial effect repeated injections are also of value in the treatment of this disease.

FLORIDA EAST COAST MEDICAL MEETING

The program of the joint meeting of the Florida East Coast Medical Association, the Duval County Medical Society and the Radiological Society of Florida, is practically completed with the exception of a few details which will be announced to members later. On the afternoon of October 28th, at the Duval County Hospital, the following clinics will be given:

Orthopedics, by Dr. F. L. Fort and associate.

Cardiology, by Dr. Herrman H. Harris and associate.

Pediatrics, by Dr. Luther Holloway and associate.

Neurology, by Dr. Ralph N. Greene and associate.

Thyroid gland disease by Dr. John E. Boyd and Dr. Edward Jelks.

Gastro-enterology, by Dr. J. Knox Simpson and associates.

Genito-urinary, by Dr. Robert McIver and associate.

Chest, by Dr. T. Z. Cason and Dr. Louie Limbaugh.

Following the clinics the visiting members and their wives will be entertained in the homes of the Jacksonville physicians.

At 8:15 p.m. the Duval County Medical Society is offering an attractive program in the form of guest speakers from the Rockefeller Foundation, followed by an informal dance, buffet supper and soft drinks, at the Mayflower Hotel, which the members of the Florida East Coast Medical Association and Florida Radiological Society are urged to attend.

The next morning the official program of the Florida East Coast Medical Association will be given. Papers are as follows:

1. "Obstetrics vs. Midwifery," Dr. Homer L. Pearson of Miami.

2. "A Case of Combined Chylothorax and Chylous Ascites with Extensive Malignant Involvement of the Thoracic Duct," Dr. E. Gordon Fletcher of St. Augustine. Discussion by Dr. Julian Gammon and Dr. E. C. Swift.

3. "Duodenal Fistula with Three Attempts at Closure," Dr. J. W. Snyder of Miami.

4. "Transurethral Resection of the Prostate," Dr. Louis Orr of Orlando. Discussion by Dr. Maximilian Stern and Dr. Robert McIver.

5. "Early Diagnosis of Whooping Cough, Including a Study of 100 Cases," Dr. Warren Quillian of Coral Gables. Discussion by Dr. Thomas E. Buckman and Dr. Jack Peavy.

6. "Respiratory Stimulants," Dr. Joseph Rutter of Daytona Beach.

7. "Morality Among the Ancients as Compared to That of the Present Day, Supported by Biblical Quotations," Dr. John E. Hall of Miami.

Business meeting and election of officers.

Beginning at 2 o'clock the Radiological Society of Florida will convene to hold an afternoon round table session to which all are invited. Case presentations with films will be featured.

Headquarters will be at the Mayflower Hotel, Jacksonville. The officers of the Association are more than pleased with the large number of requests for papers on the program and the letters from members all over the East Coast Announcing their intention to attend. While it has been impossible to give everyone who applied a place on the program, the members can rest assured that they will be well taken care of in other ways while in Jacksonville.

The Ladies' Auxiliary of the Duval County Medical Society are making plans for entertaining the visiting ladies.

FLORIDA MIDLAND MEDICAL MEETING

The Florida Midland Medical Society meets in Tampa, at the Tampa Municipal Hospital, October 27th, with the following program:

"The Importance of the early care of Strabismus in Children," William Patterson, M.D., Tampa.

Discussion: Drs. R. L. Cline and Jos. W. Taylor.

"Prophylactic Measure in Obstetrics," S. A. Clark, M.D., Lakeland.

Discussion: Dr. W. M. Rowlett.

"Paralytic Ileus," E. H. McRae, M.D., Tampa.

Discussion: Drs. George Hardy and Ralph Torbett.

"The Importance of the early Feeding of Infants," G. S. Osincup, M.D., Orlando.

Discussion: Dr. George L. Cook.

"Diagnosis and Management of Stones in the Urinary Tract," James L. Estes, M.D., Tampa.

Discussion: Drs. J. W. Alsobrook and E. S. Gilmer.

Adjournment for lunch in dining hall, Tampa Municipal Hospital.

"Meckles Diverticulum," George E. W. Hardy, M.D., Tampa.

Discussion: Dr. E. H. McRae.

"Pyuria in Children," James R. Boulware, M.D., Lakeland.

Discussion: Dr. N. L. Spengler.

"Dyscrinism in Infants and Children," Nathaniel L. Spengler, M.D., Tampa.

Discussion: Dr. George L. Cook.

"The Doctor's Part in Public Health," A. C. Hamblin, M.D., Valrico.

Discussion: Dr. T. F. Jackson.

"Pulmonary Tuberculosis, Sunshine and Violet Ray," Allen F. Higgins, M.D., Tampa.

Discussion: Dr. G. C. Freeman.

Jos. W. Taylor, M.D., President; Robt. C. Black, M.D., Sec'y-Treas.

CORRESPONDENCE

To Members Florida Medical Association.

GENTLEMEN:

A new display card for physicians' offices and other appropriate places has been printed by the State Board of Health and is available for free distribution. It bears the following legend:

IS YOUR CHILD PROTECTED AGAINST

DIPHTHERIA

SMALLPOX

TYPHOID

SEE YOUR DOCTOR

State Board of Health,
Bureau of Communicable Diseases.

Henry Hanson, M.D.,
State Health Officer.

Similar placards with a similar purpose were distributed and posted in doctors' offices a few years back by the District Health Officers. It is hoped that this new form will catch the eye more readily and, being a message direct from the State Board of Health to parents, afford a stronger incentive to action.

Our objective is to get children under six years of age to the family doctor for the two toxoid treatments. The sooner this is given after they are nine months old the better.

(Signed) F. A. BRINK, M.D., *Director.*,
Bureau of Communicable Diseases.

STATE NEWS ITEMS

Dr. A. L. Walters and family of Miami spent their summer vacation in North Carolina.

* * *

Dr. H. P. Bevis, Arcadia, was named one of the judges at the annual fox hunt or field trial of the Florida State Fox Hunters' Association, held at Eustis, October 3 to 7, inclusive.

* * *

Dr. P. T. Skaggs, Miami, has returned from Louisville, Ky. Dr. Skaggs' address is now 510 First National Bank Bldg., Miami.

* * *

Dr. F. S. Jennings returned the first of this month from Dryden, N. Y. He has located at 149 Second St. N., St. Petersburg.

Dr. and Mrs. Robert M. Harris, Miami, have returned from a seven weeks' vacation in the north.

* * *

Dr. Edgar S. Estes, St. Augustine, spent an extended vacation in Waynesville, N. C., during the summer months.

* * *

Dr. and Mrs. J. M. Anderson and son, George, of St. Petersburg, and son, Dr. Clyde Anderson, who is serving an internship at the Tampa Municipal Hospital, were recent visitors in Sebring.

* * *

Dr. Raymond Howe, Daytona Beach, spent several days in Philadelphia the latter part of September.

* * *

Dr. and Mrs. J. L. Chalker of Ocala were visitors in Brooksville recently.

* * *

Dr. and Mrs. M. A. Lischkoff recently spent some time in New York and Philadelphia where Dr. Lischkoff did post-graduate work.

* * *

The removal of the Orlando Clinic to 106-110 E. Central Avenue, Orlando, was announced recently by Drs. John S. McEwan, Gaston H. Edwards, Duncan T. McEwan and Lawrence C. Ingram.

* * *

Dr. Ralph Edward Smith of Jacksonville died September 25th after a brief illness. Dr. Smith practiced medicine in Jacksonville thirty-five years. He was a graduate of Emory University, Atlanta.

* * *

Dr. and Mrs. Shaler Richardson, Jacksonville, recently returned from a few weeks' visit to New York and Montreal.

* * *

The annual meeting of the Society of Plastic and Reconstructive Surgery will meet in New York City, October 28th and 29th. The profession is invited to attend. Printed programs and further information may be secured from the Society's headquarters, 30 East 40th St., New York.

* * *

Dr. and Mrs. J. H. Fellows, Pensacola, spent their vacation in New York and Canada last month. Dr. Fellows attended a number of clinics in New York during his stay in that city.

The attention of the medical profession is called to the announcement of the Fourth Annual Assembly of the Southeastern Surgical Congress which will be held in Atlanta, Ga., March 6, 7 and 8, 1933. Begin plans now to attend. The same high class program which characterized the second and third assemblies will be provided. For further information, address Dr. B. T. Beasley, executive secretary, Doctors' Building, Atlanta, Ga.

* * *

The first Institute on Health Education which will be conducted by the Public Health Education Section of the American Public Health Association will be held at the Hotel Willard, Washington, D. C., October 22, 23 and 24, 1932, immediately preceding the Annual Meeting of the Association, which opens Monday, October 24. The purpose of the Institute is to provide instruction in the content and methodology of Health Education to a limited number of persons actively engaged in Health Education. Application for enrollment in the Institute should be made on the prescribed form obtainable from the American Public Health Association, 450 Seventh Avenue, New York City. The registration fee is $5.00 and must accompany application. Payment of fee entitles the students to all privilges of the Institute and to private consultation with the instructors, if desired.

* * *

Dr. and Mrs. D. Ward White of Miami Beach returned last month from an extended visit in the New England states and Canada. Dr. White visited a number of hospitals and clinics at various points.

* * *

Dr. B. H. Lawson and family of Winter Garden spent their vacation in Georgia and Jacksonville, Fla., the early part of September.

* * *

Members of our Association who desire places on the program of the Sixtieth Annual meeting to be held at Hollywood next spring should immediately make application to the Committee on Scientific Work, P. O. Box 81, Jacksonville. Doctors who read papers at last year's convention are not eligible for places on the program this year.

L. M. Anderson, M.D., Chairman;
Leland F. Carlton, M.D.,
Edward Jelks, M.D.,
Committee.

The following members of the Florida Medical Association attended the meeting of the American Academy of Ophthalmology and Otolaryngology held in Montreal, September 19-24: Nelson M. Black, Miami; Chas. C. Grace, St. Augustine; B. F. Hodsdon, Miami; Shaler Richardson, Jacksonville; Wm. Y. Sayad, West Palm Beach; and J. W. Taylor, Tampa.

* * *

Dr. J. H. Colson and family of Gainesville spent their September vacation in Virginia.

* * *

Dr. William B. Lithgow and family of Miami have returned from a short vacation spent in Pennsylvania and New York.

* * *

Dr. and Mrs. J. E. Maines, Jr., Gainesville, recently moved into their new home at 1207 West Boulevard, Highlands.

* * *

Dr. and Mrs. J. A. Newnham of Stuart have returned from Cloudland, Georgia, where they spent the summer.

* * *

Dr. S. Aronovitz of Miami was in New York City the latter part of September, attending clinics.

* * *

Dr. Joseph Halton, Sarasota, spent some time during September in New York City, where he took post-graduate work at the medical center.

* * *

Dr. and Mrs. J. P. Esch, Daytona Beach, were visitors in Cleveland, Ohio, the latter part of September.

* * *

Dr. and Mrs. Maximilian Stern have returned to DeLand after spending the summer in New York City and Canada. Dr. Stern will be associated with Dr. Hugh West during the coming year.

* * *

Dr. and Mrs. M. D. Kirsch, who spent a summer vacation in Waynesville, N. C., have returned to Miami.

* * *

Dr. Nelson Pearson, Miami, was a visitor in St. Louis and Louisiana, Mo., recently.

* * *

Dr. and Mrs. Russell H. Dean, Jacksonville, spent their vacation in Waynesville, N. C., last month.

Dr. J. D. Chunn has moved his furniture and fixtures from Kissimmee to his home on Pennsylvania Avenue, St. Cloud. Dr. Chunn found the work of traveling between Kissimmee and St. Cloud too strenuous and the hours too long in keeping both offices open.

* * *

Dr. J. E. Rawlings, Daytona Beach, was recently appointed chairman of the finance committee of the local post of the American Legion.

* * *

Dr. Marvin Smith and family, Miami, spent six weeks this summer in the north. Dr. Smith attended the Mayo Clinic at Rochester, Minn., returning via North Carolina.

* * *

Dr. and Mrs. H. V. Weems, Sebring, announce the arrival of a daughter, Wednesday, August 31st.

* * *

Dr. Geo. Scott McKnight and family of Sebring were recent visitors in Haines City.

* * *

Dr. W. S. Pyatt of Bowling Green was a visitor in Arcadia in the early part of September.

* * *

Dr. D. L. McSwain, Arcadia, spent a two weeks' vacation at Defuniak Springs the early part of September.

* * *

Drs. F. J. Costa and J. A. Minardi of Tampa, honorary members of the Sigma Iota fraternity of the University of Florida, were principal speakers at a luncheon meeting of that organization, held recently.

* * *

Dr. M. H. DePass of Gainesville spent the month of September in Connecticut and Canada, returning the early part of this month.

* * *

Dr. and Mrs. C. Larimore Perry of Miami spent the month of September at Highlands, N. C.

* * *

Dr. A. C. Knight and family of Jacksonville spent their summer vacation on Sugar Loaf Mountain in North Carolina.

* * *

Dr. L. H. Dame and family of Inverness were visitors in Ft. Pierce recently.

Dr. Elliott M. Hendricks and family of Ft. Lauderdale spent a month's vacation in the mountains of North Carolina this summer.

* * *

Dr. T. C. McGuire of Plant City was a visitor in Charleston, South Carolina, the latter part of September.

* * *

Dr. and Mrs. Henry Fuller of Mulberry were in North Carolina last month visiting relatives.

* * *

Dr. and Mrs. Gordon Stanton of Hastings have returned home after having spent the summer in South Carolina.

* * *

Dr. Hugh West of DeLand returned last month from an extended trip abroad. He studied in Vienna, Austria, Italy, France and Switzerland.

* * *

Dr. W. Lee Ashton of Umatilla recent y made a trip to Palatka where he visited his parents.

* * *

Dr. J. Davis Forster, Sr., Daytona Beach, and his son, David, Jr., recently opened offices at 326 South Beach St., where they will be associated in practice.

* * *

Dr. J. E. Harris, Sarasota, and Miss Rebecca Eastman, Springfield, Mass., were married at Springfield, Mass., September 10th. They will make their home in Sapphire Shores, Sarasota.

* * *

Dr. J. A. Mease and family, Dunedin, spent their vacation in September touring some of the western states. Dr. Mease attended a number of clinics and medical centers while on his vacation.

* * *

Dr. Lloyd Netto, West Palm Beach, made a trip last month to Nashville, Tenn., and other points of interest. He was accompanied by his mother and grandmother.

* * *

Dr. J. W. Alsobrook and family of Plant City spent their vacation at Indian Springs and Atlanta, Georgia, recently.

* * *

Dr. and Mrs. Samuel Puleston of Sanford made a brief trip to Ft. Myers in the early part of September.

* * *

Dr. and Mrs. J. B. Dowling of Alliance are receiving congratulat'ons on the arrival of a baby boy, born August 28th.

Dr. J. C. Tillman and family of Gainesville spent several weeks in Minnesota last month. They returned by the way of Kansas City where they visited relatives.

* * *

Dr. O. H. Cribbins, Sarasota, spent his vacation last month in Louisville, Ky., and nearby cities, where he visited friends and relatives.

* * *

Dr. and Mrs. E. I. Carefoot of Jacksonville were visitors at Ft. Meade in the early part of September.

* * *

Dr. H. E. Miller of New Smyrna spent several days in Atlanta last month.

* * *

Dr. and Mrs. Thomas W. Hutson of Miami returned last month from a trip to Rochester, Minnesota, and other points of interest.

* * *

Dr. H. L. Merryday and family of Daytona Beach have returned from a short vacation trip to Waynesville, N. C.

* * *

Dr. and Mrs. A. M. Bidwell of Tampa returned last month from Asheville, N. C., where they spent a two weeks' vacation.

* * *

Dr. L. M. Anderson, Lake City, chairman of the Committee on Scientific Work, was a visitor in Jacksonville recently, where he conferred with some of the members of the State Association.

* * *

Dr. Roy Howe and family, Daytona Beach, returned recently from a visit in Hampton, S. C.

* * *

Dr. Warren Quillian, Miami, was the principal speaker at an institute held by the Dade County Council of Parent-Teacher Associations last month. Dr. Quillian discussed the proper feeding of children.

* * *

Dr. and Mrs. J. G. Gainey of Quincy spent a short vacation in North Carolina last month.

Situation Wanted: By Office Assistant.—Experienced assistant and secretary desires position in office or clinic. Ten years in last position in Jacksonville. Trained in medical stenography, bookkeeping and all office details. Well grounded in surgical technique and competent to do minor dressings, treatments and clinical examinations. Unincumbered. L. A. certificate. Mrs. Anna Henry, Box 81, Jacksonville.

COMPONENT COUNTY SOCIETIES

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society met at the Hotel Simmons Thursday evening, September 15th. Papers were read by Drs. John S. Helms, Jr., and James S. Grable of Tampa. The meeting was well attended.

ORANGE COUNTY MEDICAL SOCIETY

The Orange County Medical Society held its September meeting, the evening of the 21st in the lounge of the Orange General Hospital with President G. S. Osincup in the chair. Dr. T. M. Rivers of Kissimmee read a very interesting paper on Allergens, which met with much critical discussion. The suggestion was made that the scope of the paper was so wide that if the subject matter is all positive it would so change the picture of medical diagnosis and practice that a new text-book on the practice of medicine should be written by the genial essayist.

Dr. Mallory introduced an active discussion regarding the Orange County Medical Clinic and as a result of this the former committee was discharged and a new board of governors were elected consisting of the president of the Orange County Medical Society, the City Health Officer and the County Health Officer, these positions today being occupied by Dr. G. S. Osincup, Dr. C. D. Christ and Dr. H. M. Beardall, respectively.

An announcement was made of the impending meeting in the lounge of the San Juan Hotel, Saturday evening, October the 8th, at eight o'clock, bringing together the official members of the State Board of Health and the Florida Medical Association. All associates of the society were urged to be present.

SARASOTA COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Sarasota County Medical Society was held Tuesday evening, September 20th, at the Beach Club, Sarasota, with Dr. Jack Halton, presiding. A feature of the meeting was an address by Dr. Allen F. Higgins of Tampa. Dr. Higgins discussed the problems dealt with by the physicians in the treatment of tuberculosis. Dinner was served during the evening.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, Inc.

State Editor

Mrs. S. E. Driskell

1110 Windsor Place

Jacksonville, Florida

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It is now time for the Auxiliaries to be starting their year's work.

Feeling that an exchange of ideas is always helpful, the monthly news this time is to be made up of excerpts from a compilation of various state activities sent out by our efficient national press and publicity chairman, Mrs. Milton P. Overholser. It is hoped that our county Auxiliaries may find these suggestions helpful in their work.

Missouri's Auxiliaries are each having a program on the Story of Jane Todd Crawford They are sponsoring a tuberculosis essay contest in Junior and Senior high schools—with cash prizes in gold to the winners.

The Bell County, Texas, Auxiliary organized a Health Club among school children and a number of health plays were presented. Outstanding among the latter was "The Magic Fluid" which was given on May first in celebration of National Child Health Day.

The Bexar County Auxiliary of Texas sponsored a child health play, "May Day Old and New," for May first, a cast of 200 children taking part. Cooperation was given in producing the play by the city recreation department, and it made a great appeal to the large and appreciative audience.

The following paragraph is quoted from a report of the Shreveport, Louisiana, Auxiliary: "An important work of the health committee has been to secure dependable health programs for various organizations, and for children of the schools. The doctors of Shreveport have offered

to go to any organization and speak on health subjects. Many of the Parent-Teacher Associations have welcomed this offer and have requested health talks. The Shreveport Medical Society cooperates with us in finding the speaker most suitable for the subject and occasion.

The committee furnishes each school library with an instructive pamphlet on Communicable Diseases."

The Auxiliary of Delaware assisted in the State Anti-Tuberculosis Educational Campaign. Mr. Doyle E. Hinton, Executive Secretary of the Anti-Tuberculosis Society, wrote to the president as follows: "The Woman's Auxiliary rendered this office the finest type of assistance without which this campaign could never have succeeded in either scope or effect as it did.

There is no organization in this state holding the strategic position to further the health well-being of the citizens in an educational sort of way which is held by the Woman's Auxiliary."

In Georgia the Auxiliary cooperates with the State Department of Public Health and the Medical Association in Regional Health Conferences with such results as increasing the number of health units, educating the public on child welfare, common defects, communicable diseases, social hygiene, sight conservation, periodic health examinations, etc.

Jefferson County, Kentucky, Auxiliary used the following subjects for discussion at their own meetings last year: Early American Physicians, American Medical Schools and Hospitals, Outstanding American Physicians, Kentucky's Part in American Medical History, and Medical Progress in the Twentieth Century.

The Denver, Colorado, Auxiliary has a "Presidents' Day" on which the presidents of other outstanding women's clubs of the city are invited to attend the Auxiliary meeting.

Dr. C. A. Boice, chairman Advisory Committee Woman's Auxiliary of Iowa, writes: "A Woman's Auxiliary to the County Medical Society should be a part of each county organization. Medical education of the laity should come from but one source—the State Medical Society. The active and willing cooperation of the State University and of the State Department of Health are assured. Wives of doctors have representation in every woman's organization in the country and can exert a potent influence in seeing that reputable medical education is presented wherever the opportunity offers. We urge that the county society offer its good offices to the ladies in order to organize a Woman's Auxiliary."

Most all the states are especially interested in their scrap-books and in gathering data for their archives.

In this news letter that Mrs. Overholser sends to all the state presidents and press chairmen, she wrote of Mrs. Freeman's visit to Florida and about her having personal contact with five County Auxiliaries previous to the state meeting. She gives Florida credit for giving due attention to its scrap-book, and tells of the historical data that has been collected.

Will not you county presidents and press and publicity chairmen send in reports of your meetings and of your work promptly to the state editor so that what you are doing may inspire others to carry on, and so that Florida may receive her rightful recognition as an important factor of the National Auxiliary work?

ADVERTISER'S NOTES

A CONVENIENT NEW PHARMACOLOGY OF THE MEDICINAL AGENTS IN COMMON USE

The student of medicine will always find the large standard texts on pharmacology indispensable for critical study of the actions and uses of drugs. These texts, however, are in many instances so voluminous that they are not available for ready reference or for study in spare moments.

Heretofore there has been no comprehensive, small-size work on pharmacology. To meet this need Dr. Stanley Coulter, Dean Emeritus of the Purdue University School of Science, spent over three years in the preparation of a compact treatise on the pharmacology of the drugs now in common use by the medical profession. In this work he had the cooperation of members of the medical and research staffs of the Lilly Laboratories.

The subjects are alphabetically arranged for quick reference. Under each title there is a terse statement of the constituents of the drug, its physiological action, dosage, and brief mention of its more important therapeutic uses.

This Pharmacology is prepared with special attention to the needs of the medical student. The main part of the text dealing with individual drugs is followed by an appendix of tables and miscellaneous information useful to the medical student. In no sense is this book intended to



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supplant the larger standard texts on pharmacology. On the other hand, it is the hope of its author and the publishers that the use of the pocket-size book will so intrigue the student in the subject that he will be led to closer studies of the great authorities on pharmacology.

The book is supplied in flexible fabricoid binding, 254 pages, 3⅜ by 6 inches, green edges; published by Eli Lilly and Company, Indianapolis; price 50 cents per copy postpaid.

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Mild cases	15 "	30 "	

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*Until the proper amount for their age and condition is reached, which is 200 c.c. per kilo of body weight per twenty-four hours, or three ounces per pound of body weight per twenty-four hours. However, the total twenty-four hour intake need not go above thirty-two to thirty-five ounces or 960 to 1050 c.c.

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and Dextrins) should be added gradually, beginning with one ounce to the quart, and increasing until the infant is gaining steadily in weight. In certain cases, it may be necessary to increase the carbohydrate to a total of 12 to 15% (3 to 4 ounces of carbohydrate to the quart).

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912.

of THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., published monthly at Jacksonville, Florida, for October 1, 1932.

STATE OF FLORIDA, } ss.
COUNTY OF DUVAL. }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Shaler Richardson, M.D., who, having been duly sworn according to law, deposes and says that he is the editor of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of Publisher, Florida Medical Association, Inc. Post-office address, Box 81, Jacksonville, Fla.

Editor, Shaler Richardson, M.D. Post office address, Box 81, Jacksonville, Fla.

Managing Editor. None.

Business Manager, Stewart G. Thompson, D.P.H. Post office address, Box 81, Jacksonville, Fla.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.) Florida Medical Association, Inc. (A corporation not for profit—no stockholders).

Gerry R. Holden, M.D., President, 1022 Park St., Jacksonville, Florida.

Jack Halton, M.D., 1st Vice-Pres., Sarasota, Florida.

Eugene G. Peek, 2nd Vice-Pres., 104 So. Magnolia St., Ocala, Florida.

W. C. Thomas, M.D., 3rd Vice-Pres., Gainesville, Florida.

Shaler Richardson, M.D., Secy-Treas., Box 81, Jacksonville, Florida.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest, direct or indirect, in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is (This information is required from daily publications only.)

FLORIDA MEDICAL ASSOCIATION, INC.,
By Shaler Richardson, Editor.

Sworn to and subscribed before me this 13th day of October, 1932.

Fannie E. Cromer,

(SEAL) Notary Public State of Florida at Large.
(My commission expires August 21, 1934.)

Form 3526—Ed. 1924.

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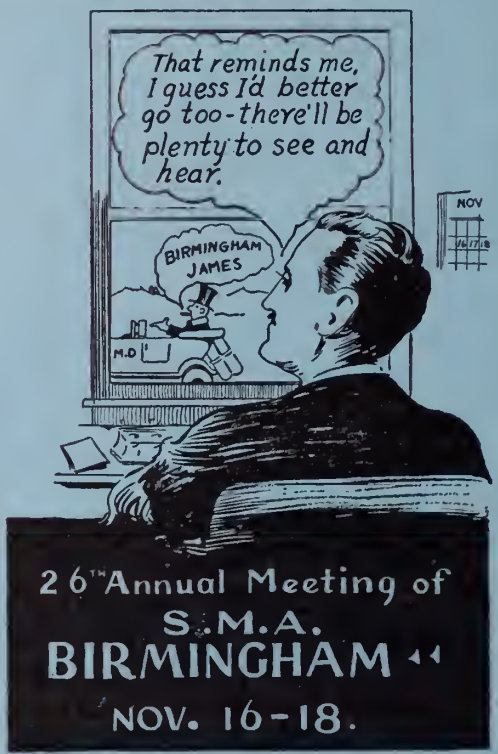
SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	
Bay	W. J. Lee, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital	No.	
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	Louis Orr, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	V. M. Johnson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	No.	
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. C. Patterson, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	
Washington-Holmes						

NOTE—Secretaries: Please submit information to complete the above schedule.

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THE JOURNAL
— OF THE —
Florida Medical Association, Inc.

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VOLUME XIX
NO. 5

Jacksonville, Florida, November, 1932

Yearly Subscription, $3.00
Single Copy, 30c

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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXIX Jacksonville, Florida, November, 1932 Number 5

THE DIAGNOSIS OF CHRONIC APPENDICITIS*

E. W. Bitzer, A.B., M.D., F.A.C.P.,
Tampa.

A famous clinician once remarked: "The stomach is the biggest liar in the body." This statement is even more applicable to the appendix. Increasing experience usually leads to greater confidence in diagnostic ability, but in the case of the "chronic appendix" the reverse is true. Widely different opinions, expressed by such men as Deaver,[1] Carnett,[2] and Bettman,[3] emphasize the defects in the methods of studying these cases and the difficulties encountered in arriving at the correct conclusions. Alvarez's[4] study of five hundred cases of indigestion and abdominal discomfort found that only one hundred and seventy-five cases were the result of organic disease of the digestive tract. In this group, there were only seventeen definite and eight suspected cases of subacute or chronic appendicitis.

Subsequent observation of appendectomized patients, with due allowance for psychic factors and coincidence, suggests that there is a certain type of patient with chronic abdominal complaint who is relieved by an appendectomy in spite of the lack of pre-operative evidence of chronic appendicitis. Such patients are usually found in the service of surgeons who operate on suspicion, and who have a high percentage of failures.

PATHOLOGY AND PATHOLOGICAL PHYSIOLOGY

In a pathological examination of 3,214 appendices, Rhodenberg[5] found chronic productive inflammatory changes in 1,374. Similar changes were also found in the neck of the gall-bladder. Changes found in the local nerves suggested a general involvement of the splanchnic system. Masson[6] found a hyperplasia of the muscular system, and both Meissner's and Auerbauch's plexus, even to the point of ill defined neuromas, associated with atrophy of the lymphoid tissue. McIntosh's[7] study of 310 cases showed fecoliths in 48, kinks in 37 and fibroid changes with or without an obstructed lumen in 55. He suggests that allergy is a factor in chronic appendix conditions, basing this assumption on finding eosinophilic infiltration and Charcot-Leyden crystals in 44 of 135 cases. Fifty per cent[8] of all appendices show obliterative changes after 60 years of age. Whether this is caused by inflammatory conditions or is due to senile degeneration in a rudimentary organ is not known. In complete obliteration, from a clinical standpoint, nature has removed the appendix as effectively as a surgical removal.

Poynton[9] has called attention to the fact that in general infection of the rheumatic fever type, inflammatory changes are common in the appendix. Recently, Alvarez[4] has expressed the belief that many obscure abdominal conditions associated with a tender liver and occasional fever and joint conditions are due to chronic, low grade, general infections.

Gordon[10] has reported 221 cases of oxyuriasis in 20,969 extirpated appendices and McIntosh[7] found 10 cases that showed vegetative types of endameba hystolytica in 310 appendices. It is doubtful whether either of these bears any etiological relation to the problem of the "chronic appendix."

The diversity of symptoms attributable to the pathological changes found may be explained in five ways.

First: Local symptoms, that correspond more or less to the position of the organ. In 15%[11] of these cases the appendix is in an abnormal situation and thus the location of the pain is changed.

Second: Direct involvement of other organs such as the bladder, ureter, etc., producing symptoms referable to the point of contact, that are confusing and hard to interpret.

Third: Reflex spasm[11] of the junctional points or segments in which sphincter action occurs, such as the pylorus, ileo-cecal, mid-colic and pelvi rectal sphincters may produce a variety of pains in various locations in the abdomen. This condition may occur, however, from other causes: migraine, mobile cecum, spastic states of the colon, mucus colitis.

Fourth: Symptoms from the disturbance of the normal gastro-intestinal gradient.

Fifth: Symptoms that arise from involvement of the splanchnic system. This offers a plausible

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

explanation of the failure to recover and the delayed recovery that is occasionally seen.

HISTORY AND SYMPTOMS

A history of acute attacks is probably the most important and suggestive information obtainable. This, however, is lacking in a large percentage of cases.

AN ANALYSIS OF 120 CASES IN WHICH APPENDECTOMIES WERE DONE FOR CHRONIC APPENDICITIS. (THE AVERAGE TIME AFTER THE OPERATION WAS 7.8 YEARS.)

Cases showing no relief	51
Cases showing partial relief	17
Cases showing complete relief	47
Cases relieved within one year	3
Cases relieved within three years	1
Cases operated on without symptoms	1

	Relieved	Not Relieved	Total
Pain in right lower quadrant	47	21	68
Epigastric Pain, (no relation to food)	8	3	11
Indigestion, indefinite type, epigastric swelling, belching.	10	13	23
Epigastric pain after meals	2	1	3
Epigastric pain between meals	2	17	19
Heart Burn	1	12	13
Pain in lower anterior chest	1	2	3
Pain in whole lower abdomen	3	3	6
Pain in left lower abdomen	2	1	3
Pain in umbilical region	2	2	4
Pain in whole left abdomen	2	2	4
Pain in right thigh and back	1	0	1
Nausea and vomiting	9	4	13
Vomiting blood	1	0	1
Rectal pain	0	1	1
Dizziness	0	3	3
Other remote symptoms	0	1	1
Diarrhea	0	1	1

Duodenal Ulcers were definitely present in	7
Mucus Colitis	5
Migraine	1
Food Allergy	1

This study suggests that pain in the right lower quadrant is the most common symptom. Pain may occur in any part of the abdomen. Any type of indigestion may occur, but the acidity types, heart burn and pain between meals are rarely relieved by operation. All these symptoms may occur from other causes than "chronic appendicitis."

PHYSICAL EXAMINATION

Palpation of the abdomen for tender points, while difficult to interpret and at times misleading, is generally most useful. The classical sign of a diseased appendix, tenderness at the Morris' and McBurney's points, is usually present. These tender points, however, may be present in any other condition, after appendectomy, and frequently in absolutely normal abdomens. The epigastrium and right lower quadrant are low threshold points for pain, and tenderness may be entirely a result of a hypersensitive nervous system. On the contrary, in proved cases, it is not uncommon to fail to elicit tenderness in the right lower quadrant, even in acute cases. In 163 cases, 122 showed tenderness at McBurney's point; 109 at Morris' point; 45 in the epigastrium; 20 in the right hypochondrium and, 3 were absolutely negative as to tenderness.

An extensive study of skin hyperthesia in chronic disease of the appendix suggests that it has no specific diagnostic value, but is useful as a means of estimating the sensitiveness of the nervous system. Many special methods of examination have been advocated;[11, 12, 13, 14, 15] but their value has not been proved.

The X-ray is the most useful single method of examination. With the technique of Czepa,[8] or Brown,[16] failure to visualize the appendix is suggestive of pathology. Where the appendix is visualized the degree of sensitiveness, position and mobility are important, and also the emptying time. Roentgenograms alone should never be used, however, as a justification for appendectomy, unless other confirmatory evidence is established.

DIFFERENTIAL DIAGNOSIS

- Originating in the Nervous System
 1. Malingering.
 2. Neurosis and psychoneurosis.
 3. Psychic pain.
 4. Under-nutrition, incipient deficiency diseases.
- Somatic in Origin
 1. Sacro-iliac disease.
 2. Disease of psoas muscles.
 3. Spinal arthritis.
 4. Intercostal neuralgia.
- Visceral in Origin
 1. Pain in the lower abdomen.
 a. Incipient hernia.
 b. Rectal disease.
 c. Pelvic disease.
 d. Disease of colon, colitis, diverticulitis, etc.
 e. Disease of cecum, foreign bodies, tuberculosis, cancer, ulcer.
 f. Disease of ureters, kidneys.
 2. Digestive.
 a. Peptic ulcer.
 b. Duodenitis, gastritis.
 c. Dilatation of duodenum.
 d. Disease of gall-bladder and liver.

An adequate discussion of this important subject is impossible, but it is necessary to emphasize the usefulness of classifying the case, in reference to the origin of the symptoms. Are they nervous, somatic or visceral? This can only be done after a thorough examination, systematically carried out. The most troublesome class is the nervous cases, in which it is often impossible to give an opinion, except after prolonged observation. Recently, a young girl admitted that she had had her appendix removed by a well-known New York surgeon for the sole purpose of cre-

ating some excitement and gaining the attention and sympathy of her family. In another case, a highly nervous woman who considered herself in an impossible predicament, developed a severe pain in the right lower quadrant, following repeated palpitation of the abdomen, and embraced chronic invalidism as a means of dodging her difficulties. On the contrary, it is not logical to assume that a case with nervous manifestation has no organic disease, without a most careful investigation.

THE RELATION OF THE "CHRONIC APPENDIX" TO THE ULCER PROBLEM

Rivers,[17] has suggested that duodenitis and gastritis are pre-ulcerous lesions. It has been proved that this condition is not uncommon in chronic appendicitis cases, and accounts for the occasional gastric hemorrhages. Many surgeons believe that the removal of a diseased appendix has a very beneficial effect on a peptic ulcer. Others routinely remove the appendix during an operation for peptic ulcer. In 150 cases of peptic ulcer, 28 showed suggestive evidence of a pathological appendix. Sixteen cases had had appendectomies prior to the onset of ulcer symptoms. Thirteen had appendectomies during the course of the ulcer, and in none were the symptoms relieved. Duodenitis and gastritis, however, are usually relieved by appendectomy, either directly, from the removal of the appendix or, indirectly, from the rest in bed and a restricted diet.

CONCLUSIONS

Both pain in the right lower quadrant, and chronic indigestion may originate in a pathological appendix.

A positive diagnosis of a "chronic appendix" cannot be safely made from direct evidence alone, but must be supplemented by a process of eliminating all other possibilities.

Various types of indigestion and pain in the right lower abdomen occur in these cases but are not characteristic.

The pathological appendix is related to some extent to the ulcer problem, but the removal of the appendix is not followed by cure of the ulcer.

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DISCUSSION

Dr. John S. Helms, Tampa:

The question as to the existence of chronic appendicitis, as a clinical entity, has been "battle-ground" among distinguished surgeons for many years. Such distinguished names as Deaver and Maynihan, Hertzler and Walton appear as proponents and opponents in the controversy.

That there is such a disease as acute appendicitis cannot be controverted. That this disease is best treated by immediate operation is equally true. The failure to cure is delay in proper surgery. The mortality is high, it may be said, to the discredit of those who delay the application of good surgery and is not due to the failure of such surgery.

An acute recurring or relapsing appendicitis may occur where the individual attack may be mild and is recovered from. Such mild attacks untreated, may recover completely without residual evidence of the disease, the patient to suffer later repeated attacks of similar kind.

If irritation involves only the fixed tissue cells, exudate is quickly absorbed and normal restoration occurs. No obvious changes may remain following a moderate degree of polynuclear infiltration.

Should parenchymatous tissue be actually destroyed there is no replacement in kind, and degrees of scarring dependent upon the amount of destruction takes place.

A scarred appendix is not necessarily the seat of present symptoms. A condition of scarring does not represent a continuing process, therefore, with the conception of a recurring, or relapsing appendicitis, there is no basis for a difference of opinion. Diagnosis is easy and the indications for surgical treatment are clear. The results of such treatment are uniformly excellent.

The conception of a continuous process of inflammation in the appendix, or a chronic appendicitis, is open to serious question. Its diagnosis is as difficult as the doubt of its existence is outstanding.

We feel that probably Bernhard Steinberg was right in adding to the terminology of diseases of the appendix the term "appendicosis." This term applies to all those appendices which are quiescent as to acute infection or inflammation but show the effects of former attacks of acute infection and inflammation as evidenced by scars, fibrosis and other pathological changes.

Dr. Bitzer, in his conclusions, sums up the situation with respect to the diagnosis of chronic appendicitis in a most conservative manner. Pain in the right lower quadrant with indigestion may originate in a pathologic appendix, but various types of indigestion with pain in the right lower quadrant may occur in these cases but are not characteristic.

The disease cannot be diagnosed upon direct evidence alone. The ulcer problem, as well as gall-bladder and other gastrointestinal diseases must be considered and definitely eliminated before a diagnosis of chronic appendicitis can be justified.

Many believe that the case of chronic appendicitis of the nonrecurrent type cannot stand. A wit has said: "Chronic appendicitis contributes only to the support of a noble profession." This may be a cynical truth.

Dr. J. Knox Simpson, Jacksonville:

I feel at times that the more I see of appendicitis the less I know about what to expect in the way of pathology of the organ before its removal. This applies to both acute and chronic cases. I know of no single criterion or set of criteria which we may safely use as a specific guide in appraising the pathologic situation in the appendix before its removal.

Dr. Bitzer's paper was very interesting to me, and his critical analysis left a sense of disappointment in our minds relative to what we may expect in the way of results, from removing chronic appendices. There is a definite group of people, however, with a train of symptoms which we call chronic appendicitis, who have been thoroughly studied, and no other evidence of trouble found. They demand some sort of relief. When we are unable to relieve them by simpler means, I think we are justified in assuming that the appendix is chronically involved. I do not think that "chronic inflammation" is the proper term to use, nor do I think it properly describes the pathology present. I think that these appendices are mechanically crippled in some way, either by adhesions, constrictions of the lumen, or malposition to such an extent that they are not able to fill and empty normally and easily. I do feel that there is such a thing as appendiceal colic, and that at times a fecolith or a foreign particle gets into the appendix and is unable to get out. I have always felt that my case was considerably strengthened in such situations when the radiologist reported that the appendix either did not fill properly, or filled and did not empty properly.

Relative to the effect of trouble in this quadrant of the abdomen on the ulcer problem: there are certain things which seem to be necessary in the production and perpetuation of a chronic peptic ulcer. One is pylorospasm, giving rise to an accumulation of an excessively acid stomach content in the ampula of the stomach; its forcible propulsion into the duodenum, and the consequent instigation of both mechanical and chemical trauma to the ulcer area of the duodenum, and to the lesser curvature of the stomach. I think we may assume that frequent closure of the pylorus in spasm, in response to a message from the appendix area to the effect that trouble is brewing there, and gastrointestinal contents should be interrupted at its source for the time being, may eventually lead to chronic pylorospasm. This, in turn, may lead to the other requirements for the production of an ulcer. In addition to this, I feel that focal infection in this area may at times lead to metastatic infection in the ulcer areas. This, I think, establishes an etiologic relation between the appendix and ulcer.

The question of chronic appendicitis is still a highly controversial one, has been for many years, and, judging from the present status, looks rather hopeless for final settlement during the lives of any of us at this meeting.

Dr. E. W. Bitzer, Tampa (concluding):

This study was undertaken primarily with the hope that I might be able to increase my knowledge from a diagnostic standpoint. For some years I have been convicted that a certain number of cases of this type passed through my hands without relief that could have been relieved. I must confess that this study has not solved all my problems. However, it has been very interesting and has settled some doubtful points.

The question of treatment was not considered in this paper. I believe that some of the abdominal symptoms that originate in the appendix are temporary, and are relieved to some extent by medical treatment. As a rule they require the radical type of treatment.

I thank you.

BLOOD PRESSURE*

T. M. Rivers, M.D.,
Kissimmee.

Only a small minority of the people of the world have perfectly balanced bodies and the others are divided into two natural classes. These are the tonic or hypertensive class, which is made up of those individuals who tend to develop high blood pressure, angina pectoris, gastric ulcer or other kindred disease; and the spastic or hypotonic class, which includes those who tend to develop low blood pressure, asthma, urticaria or other allergic conditions. While we find only a few typical specimens of either class, on account of the modifications from intermarriage of the two types through the many generations of man's existence, these types may be followed up and most people will be found to lean more to the one or to the other type. This is what we call idiosyncrasy and it is certainly the greatest factor in the cause of variations of blood pressure. However, this is not the only cause of these variations as we will see later.

Perhaps the causes of blood pressure variations have been discussed more at random without proper scientific knowledge and thought than any other subject of so great a scientific importance to the general medical practitioner. There are several possible causes for these variations which may be better understood by reviewing the nerve supply of the heart and the arteries. The action of these organs is governed through the autonomic division of the general nervous system. The autonomic nerves, as we know, comprise two distinct systems: the thoracicolumbar system and the craniosacral system, which are better known as the sympathetic system and the parasympathetic system. On both heart and arteries, the sympathetic system of nerves is augmentory, or, more properly speaking, this system carries augmentory impulses to the heart and the arteries, while the parasympathetic system carries inhibitory impulses to these same organs. The augmentory action through the sympathetic system tends to raise the blood pressure, while the inhibitory action through the parasympathetic system tends to lower the blood pressure. With no interference from extraneous causes, the pressor action through the sympathetic system should balance the action through the parasympathetic system, making a constantly normal pressure; but, when there is interference from outside causes, this pressure may vary in the direction of the interference. We have shown how idiosyncrasy plays the most important part in the adjustment of the blood pressure of any individual; but there are other agents which may even overcome the idiosyncrasy in some individuals. Of these agencies, we may mention nerve tension from central impulses, endocrines, amines, creatinine, alkaloids and other drugs.

Of all the agencies which vary the blood pressure, impulses from the central nervous system are, perhaps, the greatest. We know how such impulses as sudden fear, grief or shock dilate the sphincters, permitting the escape of the urine and the feces. This must certainly be from the action of the nervous impulse through the parasympathetic nerves, the nerves which lower the blood pressure. Here we have hypotension resulting from impulses received through the parasympathetic nerves and the exciting agent is the mental state and not the nerves through which it is transmitted. Again, we observe someone constantly anxious about something. It may be anxiety about business worries and reverses, social affairs, or some neurotic state resulting from a menstrual disorder. The anxiety, weighing heavily on the mind both day and night, interferes with the normal rest. This class of nerve tension acts through the sympathetic nerves which carry augmentory impulses to increase the tension of the heart and the arteries and this must be one of the most common causes of hypertension as we see it in our every-day practice of medicine.

The endocrines of the body act through the autonomic system of nerves to keep up the proper balance of tension, besides their other activities. Epinephrin, the secretion of the suprarenal glands, is, chemically, an amine, and it is the most powerful amine known. It acts through the sympathetic nerves to keep up the normal pressure of the blood, and, if it is secreted in excess of the normal requirements of the body, it may produce hypertension. Its action is very powerful and it would be destructive to life if it were not held in abeyance by the restraining influence of other endocrines. Posterior pituitary extract acts through the parasympathetic nerves to lower the blood pressure. If it should be secreted in excess and there were no restraining influence from other agents, it would produce hypotension.

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

Thus, it will be seen that these endocrines must be secreted in balanced amounts to keep up the equilibrium of the blood pressure, and a diseased condition of either of these glands might result in destroying the coordination of the secretions, from which there would result corresponding change in the blood pressure. Other of the endocrines have their influence on the blood pressure, but time and space are too much limited to discuss them here.

Creatinine and some other products of metabolism, acting through the autonomic nerves, may vary the blood pressure. Creatinine is augmentory through the sympathetic nerves which means that it may increase the tension of the heart and the arteries to raise the blood pressure.

Amines from focal infections or from other sources have the power to change the blood pressure; but, like the endocrines, they do not all have the same action. Tyramine and phenylethylamine act through the sympathetic nerves to raise the blood pressure, while histamine and isoamylamine act through the parasympathetic system to lower the pressure. Putrescine and cadaverine paralyze both sympathetic and parasympathetic nerves just as is done by nicotine. All of these are amines produced by bacteria in focal infections, and, through the action of the bacteria in these focal infections, we may have hypertension from tyramine and phenylethylamine, hypotension from histamine and isoamylamine, or extremely low blood pressure approaching death from putrescine or cadaverine. Most persons having blood pressure varying from the normal have constipation, and the clogged colon is usually a focus of infection in which some of the amines are being formed. These amines vary with the strains of bacteria, the proteins in the residue contained in the colon and the absorption through the walls of the gut. Our observations lead us to believe that amines from focal infections are second only to nerve tension as a cause for variations in blood pressure.

Balance of mineral salts in the body has much to do with the tension of the blood in the vessels. Calcium, acting through the sympathetic nerves, has augmentory action on the heart and the arteries, which action would tend to raise the blood pressure. Again, it has further action in making the condition permanent by being deposted in the walls of the arteries, hardening them and destroying their elasticity. Calcium, as we know, is stored in the trabeculae of the bones, and, when the blood is slightly acid so as to cause this reserve calcium to pass into solution so that the blood may become saturated with calcium, as it may do in the presence of carbon dioxide in the systemic veins, and this carrying capacity is reduced as the carbon dioxide is exchanged for oxygen in the capillaries of the lungs, this calcium is precipitated as it passes out of these capillaries and may lodge in the vessels in the order: pulmonary veins, heart, and systemic arteries. The pulmonary veins, being in a healthy state, may not incorporate this calcium in their walls but pass it on to be deposited in the walls of the systemic arteries which are irritated by the constantly increasing pressure. In this way we may account for the hardening of the arteries in hypertension. Sodium, potassium and magnesium have their augmentory action through the parasympathetic nerves, for which reason, they tend to lower the blood pressure. Again, these last mentioned minerals tend to increase the elimination of calcium through the bowels and the kidneys, for which reason, they further overcome the pressor action of calcium by removing it from the body.

While the action of some of the alkaloids and other drugs is such as would vary the blood pressure, there is little reason to believe that either of these is a real factor in causing morbid changes in the blood pressure. Few of them seem to have direct action through the autonomic nerves as we have seen in the agents mentioned above. Ergot may be mentioned as an exception to this. Ergot is formed by the action of a fungus on the proteins of rye and some other cereals, and its active principles are amines. Of these, ergot amine seems to be in excess which causes ergot to be a dangerous drug to administer to persons having hypertension.

While we have listed several agents as possible causes of variations in blood pressure, we cannot believe that all of these agents are real factors in the cause of these variations. Nerve tension must certainly head the list with toxic amines from focal infections running a close second. Minerals, especially calcium, may be a factor in many cases. The part played by creatinine and the endocrines is uncertain, but they are possible causative factors to be eliminated in all cases. There is little reason to believe that the alkaloids and other drugs play any important part in bringing on morbid changes in blood pressure: but

their physiological actions are well considered in treating intercurrent diseases when there are extremes in blood pressure. By applying our knowledge of these causes, we are better able to determine the true causes of morbid changes in blood pressure in each case, and, when the causes are known, the methods of treating will be much simpler and relief will be more readily given.

Morbid Anatomy.—The morbid changes in the tissues from hypotension are hardly observable; but, as hypertension progresses, there are changes which become so marked that they may be discovered by any tyro in medicine. These changes progress slowly and are not observable until the disease may have progressed through many months. The walls of the arteries, being irritated by the strain from the internal pressure, may absorb the precipitated calcium to harden and thicken their walls and to reduce their elasticity. In extreme cases, this hardening becomes so marked that the arteries may be rolled under the fingers like hard cylinders or tubes. As the pressure becomes too great for the heart-muscle to withstand, the muscular walls of the left heart give way and the heart becomes dilated from internal pressure. The dilatation is greatest in the left ventricle which must withstand the greatest strain. This dilatation may continue until the muscular walls of the left ventricle actually rupture, resulting in sudden death, or the heart-muscle may withstand the internal strain and some weakened place in the arterial system may partially yield to this internal pressure, resulting in the formation of an aneurysm, or, finally, the internal pressure may be so great as to rupture an artery. If the rupture of the artery occurs in the brain, which it often does, the rupture permits the blood to escape into the brain where it forms a clot and the pressure of this clot on the nerve tissues results in the usual apoplectic condition which most often follows immediately after such rupture.

Symptoms.—Without the use of the sphygmomanometer there is no positive line of symptoms by which it is possible to make a definite diagnosis of either hypotension or hypertension. The general distinction would seem to be that hypertension most often occurs in the ruddy with rich red blood, while hypotension most often is seen in the pale anemic person; but this is not always the case, for we have often seen the opposite to be true. With either condition, there is frequently dizziness and headache. The bowels are usually constipated with either condition. In the case of hypertension, they are constipated from the tension of the sphincters, which are under the same tension as the heart and the arteries, while in hypotension, the constipation may result from the spastic condition of the descending colon, obstructing the passage of the contents by this spastic contraction. The heart-beat in hypertension is strong and distinct, being audible over the entire chest-wall in many cases, while, in hypotension, it is feebler, being limited to the cardiac area. The apetite in hypertension is excellent, while it may not be so good in hypotension, many of these being finical about their eating. The digestive disturbances in hypertension are most often of the stomach, due to the tension closing the pylorus which is under the same tension as the heart and the arteries, causing the food to be retained in the stomach too long resulting in the fermentation of the sugars and the starches, while the inhibitory action through the parasympathetic nerves in hypotension permits the food to pass through the pylorus before it is sufficiently digested, resulting in intestinal indigestion with much griping and alternations of constipation and diarrhea.

Prognosis.—Although the vitality of the one having hypotension may be lower than normal and may approach invalidism in some cases during the many years through which it runs, the prognosis of this devitalized subject is more favorable for continued and prolonged life than it is for the one having hypertension. In what would appear to be perfect health, the one having hypertension may have his life snuffed out instantly by a ruptured heart or a ruptured artery in the brain. A terminal Bright's disease may hurry such person on to a premature grave. Either one of these disasters may be the first warning of hypertension which may have progressed beyond the capacity of the medical attendant to give relief. All cases of hypertension with calcified arteries may be considered serious as to longevity.

Treatment.—The first thought in treating abnormalities of blood pressure is that of finding the true cause and then evolving plans to eliminate the cause, or to combat it if it cannot be eliminated. If there are mental worries, it may be well to insist on a rest with change of climate and atmosphere and surroundings. If the condition is due to amines absorbed from focal infections,

these points of infection should be located and proper steps taken to eliminate them. If there is imbalance of minerals in the body, this should be determined and steps taken to correct this condition. It is hardly to be expected that the cause may be traced to alkaloids or other drugs; but, if this should be found to be the condition, it should be corrected. When all of these conditions have been adjusted as far as possible, further treatment should be instituted. Diet is most important in either extreme. In cases of hypertension, it is well to reduce the proteins and carbohydrates to the minimum, while, for hypotension, these should be given in amounts approaching forced feeding. Little milk should be given to the one having hypertension, while this should be given freely to the one having hypotension on account of the lime content which is needed by the latter. As to drugs, we all know that hypertension should be treated with such drugs as should relieve the peripheral tension, which includes such drugs as the nitrites, the thiocyanates and the bromides, and, if the condition of the heart should need stimulation with digitalis, it should be given in conjunction with the dilator drugs. The kidneys may be treated by giving such drugs and using such means as should increase the activity of the sweat glands, relieving the tension on the kidneys in that way. Hypotension should receive a different line of treatment. The food, as indicated above, should contain ample proteins and carbohydrates. Calcium, codliver oil, parathyroid and other tonics should be given and all other means of building up should be undertaken.

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DISCUSSION

Dr. T. H. Bates, Lake City:

In discussing the subject of blood pressure, a comparison of high blood pressure, or hypertension, with low blood pressure, or hypotension, opens up a vast galaxy of pathological conditions which may exist. Dr. Rivers has excellently covered the subject. Two things seem to me particularly important with reference to hypertension. The subject of nervous or neuropsychiatric strain is perhaps not sufficiently recognized by all of us. Even temporary nerve strain is a very vital factor in the production of hypertension. The fact that hypertension may denote some deep underlying cause is one of the main reasons why the periodic health examination should be included in the work of the general practitioner. So often the development of a slight rise of blood pressure does portend the onset of something very important. Here in this particular climate, as in other subtropical climates, a comparison of blood pressure with those in the more northern climates will reveal that we run some 10 or 15 points lower than they do farther north. Just as an illustration, I might mention the case of a navy man. When on a southern cruise off Cuba he noticed that the blood pressure of a group of sailors was particularly low. Later on in the year, while on maneuvers in northern waters, examination of this same group

of men revealed that the blood pressure had risen from 10 to 15 points. I think that is a point that we might well consider when we are trying to determine a normal level for our blood pressure cases.

It has been a pleasure to have the privilege of hearing such a comprehensive paper as Dr. Rivers has just presented.

Dr. A. F. Higgins, Tampa:

I was very much interested in this paper by Dr. Rivers. We hear all kinds of papers in our medical societies about hypertension, but the part of Dr. Rivers' paper that most impressed me is on hypotension. These cases of hypotension come into all of our offices and they present problems that are very difficult to deal with. In most of these cases of hypotension, we generally have some change in the heart or in the blood vessels; particularly, you find these heart cases with a myocardial degeneration and the patient undernourished and anemic. There is no more pathetic patient that comes before us, I believe, than these patients that run low blood pressures.

In the limits of blood pressure, any pressure that is below 110 is regarded as a hypotension, and these patients are generally patients who are very much depressed. They are patients that we want to do all we can for, and it is very difficult. As Dr. Rivers stated in the paper, they are patients who don't need a restricted diet, but they do need a full diet, and from a medication standpoint are difficult cases to handle because of the fact that they are mentally depressed. I think every one of you have had the opportunity of seeing that mental depression which exists so frequently in these patients. They are nervous and they just seem to feel that they have lost their grip on life.

The treatment has always been a very difficult one with me. As far as the use of medicines is concerned, there is nothing that really does very much good outside of the dietetic treatment.

There is one member of this medical society whom we all know well, one of our leading doctors in Tampa, who runs ordinarily a blood pressure of 108 and weighs about 200 pounds. But I have never seen him depressed. I don't know why. There is another doctor in Tampa, a very prominent man in his specialty, who runs a low blood pressure which at times gets down to about 100. And I have never seen a man so completely, absolutely depressed as he is at that time.

These problems of hypotension, as I remarked when I first commenced to speak, are problems that we must deal with. We are dealing with our hypertension, know a great deal about it and are learning more every day. But in regard to the question of hypotension there is very little that is ever said. I have often wished and often looked for papers in medical publications like Dr. Rivers' that would take up the two subjects, hypertension and hypotension. I certainly have appreciated what Dr. Rivers has given us today.

Dr. T. M. Rivers, Kissimmee (concluding):

I want to thank both of you gentlemen for the discussion of my paper and the remarks you have made. I think that a paper becomes of value if its bad points are brought to light. There are always bad points in our papers, and I think that we make a mistake if we don't look for them. Commendation is all right, but it should not be all commendation.

Relative to the point that Dr. Bates brought out about nerve strain or nerve tension, I tried to stress that as being a most important factor in hypotension and hypertension, and would have brought this out more forcibly if I had had the time. However, it would take hours instead of minutes to read a paper that would cover all these points, so I just hit the high points.

If you will take the blood pressure and case histories of your chronic cases and as many as you can of the acute cases and follow them up, you will find that a great majority of your business comes from the patients with hypotension or low blood pressure. Few people are hysterical if they have hypertension. If the blood pressure is high, the tension of the person is high. He feels well, he eats well and he is active, goes on about his affairs. He forgets that there is such a thing as sickness. He goes along until he falls over with a paralytic stroke or ruptured heart, or an attack of angina pectoris. The person with hypotension, or low blood pressure, is the one who has a tendency to feel sick. You have just expressed it, Doctor, they are the ones that come for treatment, and they are the ones who live to be old. You will find that the people who have a blood pressure around 120 are the ones who live up into their 90's and some past 100. They have themselves cared for. They go to the doctor grunting. If it is a lady, she will grunt before her husband and he sends her to the doctor for treatment. Really, her condition is not as serious as if she had hypertension.

Another point: My patients come to me com-

plaining of low blood pressure. Some quack or some one else has advised them that the condition is very serious, down to 110. I will tell you, just to get at it personally, mine is down to 110. I try to think that I never get sick, and I insist that these people are not dangerously ill. Low blood pressure, unless it is extremely low, does not kill. People who have low blood pressure are more apt to have endocrine diseases or allergic conditions. And they are more apt to develop tuberculosis. They are more susceptible to disease. Their resistance is not so great, but they can outlive these troubles. We are learning to do away with them. Try to make your patients understand that low blood pressure is an advantage, that they will live to be old. You don't know what just a few words will do for them. Don't tell them that their blood pressure is dangerously low and that they might die from it. People seldom die from low blood pressure. Of course, it could get so low that they would die, but if the blood pressure is above 100, it really cannot be considered very serious.

A CASE OF COMBINED CHYLOTHORAX AND CHYLOUS ASCITES WITH EXTENSIVE MALIGNANT INVOLVEMENT OF THE THORACIC DUCT. CASE REPORT*

E. Gordon Fletcher, M.D.,
St. Augustine.

This case is being reported particularly for two reasons: first, because complete involvement of the thoracic duct with associated chylothorax and chylous ascites is extremely rare and, second, many features of the case suggested a tuberculous involvement of the thoracic duct, whereas the post-mortem findings were those of carcinomatous invasions of rather extensive degree.

H. D., storekeeper, white, married, American and age 28, was admitted to the East Coast Hospital, St. Augustine, April 11, 1931, because he was suffering from an aching pain in the upper abdomen, difficulty in breathing and an afternoon fever.

His mother and father were living and apparently in good health. There were five brothers dead, one of drowning and four of contagious diseases, all dying in childhood.

He, himself, had been sick with scarlet fever when 2 years old. He had also had measles and mumps in childhood. In September, 1930, he was operated upon for repair of a left inguinal hernia.

His general health had been very good until February, 1931, when an aching pain developed in his right hypochondrium and he noticed an undue sense of fullness of the abdomen soon after eating. Two months later, in March of this year, he developed pain in his chest on deep inspiration, bilaterally but more severe on the right side, accompanied by an afternoon fever, and more abdominal distress. On March 20th, he consulted Dr. Swift of Jacksonville, who had X-ray films made of the chest. His impression from the history of the case, fever and evidence of a slight pleural effusion, was that the patient was suffering from tuberculous pleurisy and he advised him regarding rest, diet and the recording of his temperature at regular intervals and to return for a subsequent examination in the course of a week.

However, the next week, the patient became very dyspneic, his appetite was poorer and the abdominal distention became so severe that he was unable to return.

About this time the patient was seen by Dr. Lockwood and myself. We found signs of fluid in the left chest cavity. There was less expansion of the left chest than the right, with dullness over the lower two-thirds, very distant breath sounds and egophony.

The right chest revealed dullness at the extreme base, posteriorly, with some suppression of breath sounds.

The abdomen was distended and dullness was found at the flanks and lower quadrants.

There was tenderness in the right epigastric region and the liver edge could be felt three inches below the costal margin.

There was no edema of the subcutaneous tissues. The genitalia and extremities appeared normal.

A lymph node the size of an almond was palpable above the left clavicle. The edge of the spleen could not be felt.

The left chest was aspirated posteriorly below the angle of the scapula and 10 cc. of a milky fluid was removed. The presence of such a type of fluid in the chest suggested to us the possibility of a tuberculous involvement of the thoracic duct with obstruction and leakage of chylous fluid into the pleural and abdominal cavities.

A fluoroscopic examination of the chest re-

*Read before the Florida East Coast Medical Association, Jacksonville, Oct. 28, 29, 1932

vealed the following: right diaphragm high, with very little excursion and considerable fibrosis throughout the entire lung field except for the apex, which appeared to be clear. The left diaphragm was obliterated and there was a dense shadow extending as high as the third rib, anteriorly. The remaining upper portion of the lung field was very clear. The heart was centrally placed and slightly enlarged. The abdomen was very dense and apparently contained fluid.

Stereoscopic X-rays of the chest were made after 35 ounces of milky fluid had been aspirated from the left chest. They showed an area of density, extending to the 4th rib, anteriorly with less density than revealed on previous fluoroscopic examination. The hilus gland shadows were very distinct and appeared enlarged on the right. There were also a few calcified glands but no distinct picture of tuberculous glands could be visualized. The apices appeared quite clear.

The heart shadow appeared enlarged, suggesting pericardial effusion. Laboratory examinations were made of the blood, urine, sputum and aspirated fluid.

The hemoglobin (Dare) was 78%, red blood cells, 4,100,000; white blood cells, 12,200; differential: polymorphonuclears, 65%; eosinophiles, 1%; lymphocytes, 22%; mononuclears, 10%. The Wassermann reaction was negative. The evening specimen of blood was examined for filariae but none were found. The sputum was examined on three occasions and was always found to contain many pus cells, a variety of organisms but no tubercle bacilli. An interesting finding was the presence of many fat globules.

The urine varied in specific gravity from 1010 to 1028. It was free from albumin for the first few weeks and showed no casts until the terminal days of the disease. Urate and phosphate crystals were always present. Tests for chyle in the urine were negative.

Fluid removed from the chest on April 11th contained 1% butter fat and on the 16th, 2%. A similar milky fluid removed from the abdomen on April 14th and 16th tested 4% butter fat. All specimens were cultured but no bacterial growth was secured. Differential cell counts on these fluids showed a preponderance of lymphocytes, ranging between 86% and 92%.

On May 6th specimens of fluid were injected into three guinea pigs by Captain Stimmel at Flagler Hospital. Two months later these animals were reported as appearing healthy and gaining in weight.

The course of the patient in the hospital was marked by periods of extreme dyspnea with pain confined to the lower chest and upper abdomen. Aspiration of fluid from the chest and abdomen would relieve these symptoms fairly well but the recurrence of fluid was so rapid that he required aspirations usually daily. Deep X-ray therapy was given over the lower mediastinum April 21st. For several days following this, cough and dyspnea were more troublesome than previously, but these symptoms subsided. On the 23rd of April the fluid removed from the left chest was pink colored and subsequently varied in color from light pink to chocolate. However, all fluid removed from the abdominal cavity remained a white color. Deep X-ray therapy was repeated on May 14th. Following this there was again a repetition of increased dyspnea and cough with nausea and vomiting. The following day a pink colored fluid was removed from the right chest cavity and it was necessary to aspirate this side of the chest every few days in addition to the left chest, although usually smaller quantities were removed.

Milky fluid was removed on several occasions from the abdomen. Each re-accumulation of fluid was preceded by a complaint of severe pain in the right epigastric region.

Swelling of the left thigh occurred for the first time May 24th, accompanied by considerable aching pain. Later the scrotum became swollen. These symptoms were not appreciably relieved by aspirations.

The amount of fluid aspirated from the pleural cavities during 54 days totaled 46 2/3 quarts, from the abdominal cavity 12½ quarts. Death occurred on June 8th, after 60 days' hospitalization.

We were fortunate in securing a post mortem examination which revealed a more widespread involvement of the lymphatics than was anticipated. The following notes are by Dr. Lockwood, who performed the autopsy:

Post Mortem Examination

Autopsy performed by Dr. V. A. Lockwood, June 9, 1931, 3 P. M.

External Inspection: The body is that of a white male, appearing to be approximately thirty years old. His height is estimated to be 5 feet, 8 inches, and his weight approximately 130 pounds.

The face and arms show marked emaciation. The chest is edematous, the left side being more swollen than the right. The abdomen is markedly distended, particularly in the flanks. The left leg is slightly swollen, the left foot markedly swollen. Edema of the right leg and foot is marked, and is much greater than in the opposite extremity. The scrotum is swollen to twice its normal size.

Head: External inspection reveals no abnormalities of the eyes, ears, nose, mouth and throat.

Neck: Thyroid is normal to palpation. No palpable lymphatic enlargements present.

Heart: Pericardial sac contains 60 cc. of straw colored fluid. There are no pericardial adhesions. The heart is normal in size and the epicardium, myocardium and endocardium appear to be normal. All valves are normal.

The aorta shows no pathological changes.

Thoracic Cavity: The right pleural cavity contains about 1,500 cc. of thin bloody fluid. The lung is collapsed from the pressure of fluid. There are many pleural adhesions, which can be broken fairly easily. These are most marked at the apex and at the hilus of the lung. There are fewer adhesions between the lung and the diaphragm, but one band in this situation is quite dense.

The tracheo-bronchial lymph nodes are greatly enlarged and adherent to each other as well as to all surrounding structures. The pressure of this mass is sufficient to cause obstruction to the thoracic duct. Cut section shows areas of pigmentation and of degeneration.

The cut surface of the right lung shows an extensive distribution of nodules, varying from 2 mm. to 3 mm., throughout its entire structure. The lower lobe is passively congested, boggy, filled with exudate and contains very little air.

The left pleural cavity contains 600 cc. of milky fluid. Adhesions are even more dense and widespread than upon the opposite side and are thickest at the apex and hilus. The lung is collapsed and shows the same condition of neoplastic infiltration, and of passive congestion that is present on the opposite side.

Peritoneal Cavity: The peritoneal cavity contains about 2,000 cc. of blood stained, milky fluid. There are dense adhesions between the dome of the liver and the diaphragm. A portion of the great omentum is adherent to the hilus of the liver. The lymph nodes in this region are markedly enlarged. The omentum is also adherent to the gall bladder. There are many adhesions between the cecum, ileum, appendix and parietal wall and between the sigmoid and the parietal wall of the peritoneum.

The stomach is normal in size, shape and position. There are a number of fibrinous adhesions between the different portions of the small intestine, the large intestine and the omentum. All mesenteric lymph nodes are markedly enlarged and the cut surface of any of them shows infiltration with neoplastic tissue. The tip of the appendix is congested and is bound to the ileum with fibrinous adhesions. The appendiceal and ileo-colic lymph nodes are markedly enlarged. The sigmoid contains a neoplastic mass which infiltrates the wall of the bowel for a distance of 6 cm. It does not completely encircle the gut and is not large enough to cause obstruction, although the lumen of the bowel is narrowed somewhat at this point.

The mesenteric lymph nodes in this region are markedly enlarged and hard.

The rectum is normal.

The liver is enlarged but the surface is smooth except for adhesions between its dome and the diaphragm and adhesions between the under surface of the liver, the gall-bladder and the omentum. Nodules can be palpated within the substance of the organ. There is marked passive congestion between the neoplastic nodules.

Cut section of the liver shows light yellow neoplastic masses varying from .25 cm. to 2 cm. in diameter. The lymph nodes in the hilus of the liver and in the gastro-hepatic omentum are enlarged and hard.

The gall-bladder is shrunken in size and is easily adherent to the under surface of the liver, to the great omentum and to the duodenum. The walls are thickened. Its contents are a slight amount of thick yellow bile.

The pancreas is enlarged, hardened and shows the presence of neoplastic nodules varying in diameter from 3 mm. to 10 mm. The spleen is slightly enlarged and a few nodules are palpable in its substance. The cut section shows no abnormality except the presence of neoplastic nodules.

The right kidney is larger than the left, which is normal in size. The kidneys present no gross abnormalities, the capsule stripping easily and the surface being smooth. The cut surface shows a normal appearance.

The ureters are normal.

The bladder is normal.

The following notes were made by Dr. J. T.

Bauer, Pennsylvania Hospital, Philadelphia, Pa., who made the histological studies on the specimens sent to him:

Heart: The epicardium was devoid of mesothelial cells. The fat was infiltrated with many islands of neoplastic tissue consisting of mucoid cells, usually with nuclei eccentrically placed near the edge of the cells. The vessels were partially plugged with similar metastatic nodules. There was slight associated lymphocytic infiltration. The myocardium was apparently normal except for slight degeneration or shrinking of the myofibrils.

Lung: (Several Sections) In many places the pleura was thickened first by swelling and proliferation of mesothelial and endothelial cells; secondly, edema, fibrous tissue, round cells and neoplastic cells were scattered throughout. In a few places associated hemorrhages were seen.

For the most part the alveoli of the lungs contained macrophages laden with pigment, but there were a few isolated metastases. However, the infiltration with neoplastic tissue occurred about the bronchi, within the lymphatics and in many of the blood vessels. The latter showed hyaline thrombi and tumor cells and where lymphatic tissue existed, extensive replacement of the lymph nodes' architecture by neoplastic cells had occurred.

A marked endothelial proliferation and intimal thickening of arterioles was observed throughout, sometimes associated with thrombosis, while recanalization could occasionally be seen.

Lymph Nodes: (Tracheobronchial) (?) (Several Sections) There was a moderate degree of pigment deposition throughout the fibrous tissue trebeculae. Many areas were fibrotic, infiltrated with round cells, while metastases were abundant throughout, consisting of groups of slightly basophilic cells, with marginal nuclei and swollen with mucoid material. The clumps were bathed in mucoid fluid, which they had apparently secreted. The tumor cells here, as well as in the metastases elsewhere, assumed a typical "signet ring" shape.

Lymph Node: (Mesenteric) (?) The peripheral lymphoid sinuses were greatly dilated and filled with neoplastic cells. These groups diminished toward the center but did not disappear. Pigment deposits were present in the trabeculae and phagocytosis of some of the blood pigment arising from scattered hemorrhages were noted.

Spleen: The capsule was not thickened and mesothelial lining cells appeared normal. Fibrous tissue intrabeculae were increased. Malpighian bodies were small while the vessels within them showed distinct hyaline thickening of the intimal layer. The pulp was greatly congested. A moderate degree of phagocytosis of blood pigment was seen.

Pancreas: (Two Sections) The islands of Langerhans and acinar tissue were well preserved. The vessels showed no thickening. About the larger vessels which traversed the trabeculae and throughout the peripancreatic fat were lymphatics plugged to a more or less degree with clumps and neoplastic cells similar to those described above. The pancreatic ducts were not dilated and the epithelial lining was regular.

Intestine and Mesentery: (Large Intestine) What little mucosa was seen, had been separated from the muscle, but appeared normal. The muscularis showed no changes. The mesenteric lymphatics near the attachment of the intestine contained neoplastic cells. The fat beyond was very slightly infiltrated with round cells. At a few places congestion existed. The peritoneum was a trifle thickened and where the mesothelium was preserved, the latter had undergone distinct proliferation. Occasionally a collection of fibrous and a few pus cells, and in this area, but one multinucleated, probably tumor cell was seen.

Appendix: The serosal changes were similar to those seen in some areas on the surface of the mesentery, namely, a slight compression and thickening with a few scattered infiltrating cells beneath. The mucosa was intact and glands appeared normal. It was in the submucosa that many lymphatics were filled with neoplastic cells. No lymphoid follicles were seen although a scattering of lymphocytics existed.

Liver: Occasionally, liver cells about the central vein showed compression atrophy and necrosis through slight congestion of the sinuses, but for the most part the liver cells were well preserved, containing the usual amount of bile pigment. The periportal space in one area only contained mucoid material probably arising from broken-down neoplastic cells within the lymphatics. In association with it, the arterioles were thickened and almost occluded. No other evidence of metastasis was seen.

Kidney: Except for slight swelling and granulation of the tubular epithelium, nothing remarkable was seen.

Aorta: Apparently normal.

Histological Diagnosis

1. Adenocarcinoma of intestinal tract (colon, cecum or stomach) (?) with extension to mesentery and submucosa of appendix.
2. Metastasis to lymph nodes, lung, pleura, epicardium and liver.
3. Thrombosis of pulmonary vessels.
4. Chronic passive congestion of lungs.
5. Congestion and atrophy of spleen.
6. Mild proliferations intimal arteriosclerosis.

Comment

Review of the literature reveals the paucity of cases of this type.

Chylothorax in the vast majority of cases is due to either malignant or tuberculous disease of the thoracic duct.

In chylothorax, chyle is present in the pleural cavity. The differentiation of true chyle from pseudochyle depends primarily on proving that the thoracic duct is blocked with either rupture or transudation of chyle through the duct.

According to Outland and Clendenning, chyliform fluids owe their appearance to emulsified fat, the result of morbid degeneration of cellular elements.

Pseudochylous fluids are due to opalescent substances, the exact nature of which is unknown, but which are chemically similar to lecithin.

They state that the distinctive features of chyle from chyliform fluids are:

1. The presence or absence of highly refractile granules which do not take the ordinary fat stains.
2. The amount of fat.
3. The amount of lecithin and globulin.
4. The rate of accumulation.
5. Above all, the demonstration of pathological obstruction of the thoracic duct.

The rate at which the pleural cavity fills is, according to VanNuys, between 135 cc. to 195 cc. per hour, or over 3 liters in 24 hours. It is conceivable that the fat content of the diet would have considerable effect on this flow, as we noted a slower accumulation of fluid if the patient was on a low fat diet.

VanNuys reported a case (in California and Western Medicine, April, 1931) with symptoms similar to this which apparently recovered. In his case high voltage X-ray treatment was given in the region of the lower mediastinum. He also reports that his patient was worse for 2 or 3 weeks from this treatment, his breathing and stomach being upset, but after that he improved markedly. Generally, however, X-ray therapy has been disappointing in these cases. VanNuys' case is the last one reported in the literature and he states that 66 cases had been reported in the literature during the last 250 years prior to his case.

Chyloascites is reported as being less rare thar chylothorax.

Surgery is not practical in most cases. Drainage of fluid, other than by aspiration, would apparently invite infection.

Chyle should be removed in as small amounts as possible to insure relief to the patient. Cough is an aggravating symptom if the cavity is "sucked dry" and it is conceivable that the negative intrapleural pressure produced by such a procedure would tend to interfere with healing. A certain amount of chyle may be reabsorbed through the lymphatics, but it is probably negligible.

Constant aspiration of chyle soon produces starvation and inanition before collateral chylous circulation can be formed.

The mortality in cases reviewed has been between 10% and 50%, most of the patients dying within three weeks. The prognosis depends largely upon the underlying pathological condition.

In this case it seems highly improbable that any treatment would have been successful due to widespread carcinomatous metastases.

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THE DIAGNOSIS AND TREATMENT OF CONGENITAL SYPHILIS*

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For the treatment of congenital syphilis, to attain its maximum effectiveness, the diagnosis must be made at least three years before the patient is born and treatment begun immediately upon diagnosis. To one who has only a passing knowledge of this disease, the above statement may seem exaggerated or unduly pessimistic but to one well versed in the pathology of the disease, who has seen the numerous relapses, this statement will not seem unduly pessimistic.

*Read before the Escambia County Medical Society, Century, June 14, 1932.

The use of the positive Wassermann as a criterion for the diagnosis of syphilis probably accounts for the numerous cases which are allowed to go either untreated or inadequately treated. As in all other diseases where laboratory procedures aid in diagnosis, so in syphilis, one cannot depend on the serological examination to the exclusion of clinical findings. We all well remember the aphorism of Osler: "To know syphilis is to know medicine." Hence, when one begins the study of syphilis he should remember that it is the embryological and morphological changes in the tissues that he must learn rather than to attempt to memorize certain abstract or bizarre conditions such as Hutchinsonian teeth or sabre tibias. Also, it must be remembered that the chancre which has been accepted historically as the primary sign of syphilis is rather a late manifestation of an infection which became systemic sometime before it manifested itself locally as a chancre for it has been shown that spirocheta pallida may be found in the inguinal glands within five minutes after infection of the genitalia.

The incidence of syphilis in the newly born may be placed at about three per cent, this small percentage being accounted for by the high fetal mortality from syphilis while the frequency of infection among the adult population may be placed at about eight per cent.

The infectivity of the marital partner depends directly on the duration of the disease in the partner. The chances of infection of the mate by an untreated marital partner is twelve to one in the first year, five to two in the second year, one to four in the third year and practically nil in the fourth and fifth years. The average male patient should reach a noninfectious condition in about five years but all rules will be violated by syphilis. Considerations that must be taken into account in the marriage of syphilitics are the economic status and possible neurologic complications. When these conditions are considered, it may be readily seen that some requirements for marriage must be formulated arbitrarily. Stokes' theoretical requirement for marriage is three years of adequate treatment including no less than four courses of arsenic and two years of bismuth and mercury, regardless of the initial or interim negative Wassermann. The spinal fluid test must be negative long enough to convince one that neurosyphilis has been overcome and the cardiovascular examination must be negative at all points in the fifth year.

The maternal transmission of syphilis is the usual if not the invariable rule. The greatest toll of syphilis in fetal life is taken from the sixth week to the seventh month with each succeeding fetal death occurring later, up to the seventh month. After several such fetal deaths there is usually a full term child born. The apparently normal child of a syphilitic mother is explained by a latent spirochetemia and the child, although serologically negative at birth, may later, when vitality is lowered and at the onset of puberty, show active, pathognomonic signs of the disease.

The asymptomatic mother of a syphilitic child should be regarded as a quiescent case. Few children show signs of syphilis at birth but the earlier the lesions appear the more serious the prognosis.

Snuffles and cutaneous lesions are the commonest early signs although other early signs are fissuring of the lips, condylomas at the anus, enlarged spleen, bone lesions and the aphonic cry.

Fournier gives the age incidence of symptoms of tardive heredosyphilis as three to twenty-eight years with an average of twelve years. The signs of heredosyphilis in order of frequency are: eye lesions, positive Wassermann, bosses, sabre shins, characteristic teeth, saddle nose, neurosyphilis, and mental defectives. Only twenty-two per cent of syphilitic children show normal eyes; the various eye lesions of the infected seventy-eight per cent are interstitial keratitis, choroiditis, iritis, strabismus, ptosis, optic atrophy, decryocystitis, retinitis, pigmentosa, hyalitis, vitreous opacities, uveitis, and night blindness. Interstitial keratitis is practically unknown in acquired syphilis and is so overwhelmingly an accompaniment of heredosyphilis that its diagnostic value is paramount and should be appreciated from the outset. The syphilitic child seeks medical advice most commonly for the following reasons: arthritis, abdominal symptoms, physical retardation, abnormal gait, disorders of speech, deafness, nasal conditions, cervical glands, poor mentality, paralysis and nervousness. Children presenting any of these symptoms or signs should be proven nonsyphilitic before tonsillectomies are performed. Also, children or young people who do not respond to treatment during the various disturbances of childhood and early youth should be examined thoroughly for the luetic taint. The teeth furnish one of the most common pathognomonic signs to the diagnostician. It should be remembered that only the second dentition teeth show changes distinctive of syphilis. The upper

central incisors, when typically modified by the influence of the infection, become the so-called Hutchinsonian teeth described by Jonathan Hutchinson.

Bone changes in the earlier months of life produce thickening and exostosis or roughening, especially of the shafts of the long bones. The tibia and the clavicle, being near the surface and frequently affected, are the most used diagnostic landmarks. The frontal bosses have a high diagnostic value but are relatively rare. Certain developmental stigmas such as the high palatine arch and scaphoid scapula have much lower diagnostic value. The sabre shin consists of bowing and thickening. The thickening usually involves the middle third of the shaft of the tibia.

A great deal of emphasis has been laid upon the facies of heredosyphilis relating to fullness, excess breadth and height of the forehead as well as a certain inalertness, a sleepy, tired, fagged, clouded, dreamy or obscured appearance of the face, but this has not aided me materially in making the diagnosis except in cases where the above was associated with a definite eye lesion, saddleback nose, bosses, or Hutchinsonian teeth.

Other symptoms of tardive syphilis are juvenile general paralysis, juvenile tabes, cerebral arteritis, epilepsy, spastic diplegia, precocity, and defective mentality.

The transmission of syphilis to the third generation as an inherited infection is accepted as a fact by the French syphilographers while the leading American and English writers and authorities do not accept third generation syphilis and state that the healthy child of an heredosyphilitic parent is the overwhelming rule.

In no field of preventive medicine is diligent and adequate treatment rewarded more handsomely than in that of the treatment of syphilis. In order to prevent heredosyphilis and neurosyphilis, with the attending hereditary stigmata, we must continually attempt to get nearer the source of trouble by detection of the earliest sign with subsequent immediate intensive treatment. In attacking familial syphilis we must constantly regard the prospective child of a syphilitic parent as a potential syphilitic and attempt to prevent this condition rather than to accept it as a consequence. The diagnosis of syphilis in any member of a family calls for an immediate medical examination of every member of the family.

For the mother the carrying of pregnancy to term is a reenforcement of her defense mechanism. Pregnancy is treatment for syphilis in a woman. All authorities agree that the pregnant woman with syphilis is especially amenable to treatment and that she and the child can be protected by measures which would hardly prove curative under ordinary circumstances. In fact, it is not essential unless the earliness of the infection demands it to attempt radical, curative measures during pregnancy. In untreated pregnant syphilitic women the percentage of syphilitic children is about seventy-nine while the percentage of syphilitic children born to syphilitic women who have had adequate treatment during pregnancy averages seven or eight per cent.

The treatment of syphilitic women during pregnancy may be divided into two types. First are the infections occurring coincident with or during the first six months of pregnancy which should have the regular intensive treatment consisting of two or three series of arsphenamine with bismuth injections or mercury inunctions or injections alternately. The courses should be so arranged that she receives one course of arsphenamine during the last two months of pregnancy. The second type occurs during the last three months and should receive a less strenuous treatment consisting of two-thirds the maximum adult dosage of neo-arsphenamine intravenously or sulpharsphenamine intramuscularly with a few injections of bismuth or small mercurial inunctions. There need be no rest period allowed up to within a week of term. Immediately upon birth of the baby, the mother should be given arsphenamine, mercury and bismuth to attempt to prevent neuro-recurrences, or infectious relapse. The baby should not be nursed unless the mother continues treatment with arsphenamine. The baby should be observed at least during the first fifteen years of life if humanly possible. Where the signs of syphilis appear during the first year, sulpharsphenamine and neo-arsphenamine as well as bismuth injections, fifty per cent mercurial ointment and iodides are administered at least during the first twelve months. In no case should the child be allowed to pass the third year without a spinal fluid test which is to be repeated at least by the seventh year. Neurosyphilitic changes in the spinal fluid should be treated by routine persistent intravenous and intramuscular therapy for at least two courses after which Swift-Ellis intraspinal therapy, which is well tolerated by children, may be considered. Ninety-three per cent of heredosyphilis will show clinical improvement under adequate treatment.

Mercury administered orally has no place in the modern treatment of syphilis.

Iodides must be used in the treatment of all forms where the infection was acquired as much as sixty days previously and in all heredosyphilis. The administration of iodides to a mother who is nursing a baby should be carried out very carefully due to the gastro intestinal disturbances that often occur in the nursing baby.

Before closing the subject of treatment, it is advisable to mention the treatment of acquired syphilis since in order to prevent heredosyphilis we must control acquired syphilis. Irrespective of the type of course utilized, the essential feature in the treatment of acute syphilis is that at least forty injections of arsphenamine and eighty injections of bismuth or two hundred inunctions of mercury be given, approximately eighteen months being required to complete such a course. A positive Wassermann occurring shortly after the completion of this course of treatment usually means that an invasion of the viscera has taken place and most often it is the nervous system that has become involved. At this time the spinal fluid test should be made to clear up the question of neurosyphilis and if this is found positive the patient should receive a series of sulpharsphenamine and tryparsamid injections accompanied by bismuth and mercury.

CONCLUSIONS

(1) It is easier to cure congenital syphilis by treatment of the parent before the child is born.

(2) The physician must not lean too heavily on the laboratory aids in the diagnosis of syphilis if we are to make headway in the control of this disease.

THE CONSERVATION OF THE PRE-SCHOOL CHILD'S HEALTH*

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Radio, press, pulpit and rostrum, by strenuous propaganda, are making us health as well as disease-conscious. The man of business, and occasionally other members of the family, at times, undergo annual examinations to take stock of their physical well-being or ill-being. Ofttimes, the human machine finds itself prematurely wearing out, as witness the increase in cardiac, renal, and vascular disease in our adult morbidity and mortality tables between the ages of forty and fifty-five. The jump of cardiac pathology alone to the front rank of vital statistics is significant. Regrettable as those conditions may be, yet there is a limitation to efforts directed to their amelioration, because the adult has fixed habits, tendencies, physical, mental, and emotional make-up, and efforts in his behalf, at best, can be but largely correctional.

Great progress has been made in lowering infant mortality and morbidity. Ante-natal care is rightfully assuming its place of importance, and we welcome the day when the United States shall have receded from its unenviable position of seventh place in maternal mortality, disregarding a much higher morbidity, in childbirth among the nations. During the first year of infancy, much greater attention is being paid to nutrition and hygiene and prophylaxis of diseases peculiar to this period, and results are clearly patent. Periodic examination of the school child the past twenty years has focussed the attention of every one. Millions and millions of dollars have been spent and results, while still not all desired, have been remarkable. In many of the municipalities of our own state appropriations are still being made for such purposes.

Commendable as the efforts in behalf of the adult and the school child have been, yet it is for the pre-school child particularly that we would plead. And why? He has been sorely neglected. In the round-up of the herd, so to speak, he is a scholastic maverick, with no one's brand upon him and left to roam at will. In any plan for permanent periodic health examination, productive of best results, the constant supervision of the child at this age, commands public attention first and foremost. His age is most plastic, most impressionable, most sensitive to external stimuli, most imaginative, most imitative, most subject to suggestion, most alert, most adept in response to the physical senses. Half of his knowledge of the outer physical world and its objects is attained by the age of five years. This, too, is the age when communicable, contagious, respiratory and gastro-intestinal diseases are most prevalent and most easily contracted, and for which there is ample prophylaxis in many cases. Nervous and mental disturbances often at this time show their first outcroppings. Proper habits, including dental and personal hygiene, sleep, rest, play, exercise, abundance of fresh air day and night, control of the emunctories, avoidance of fatigue,

*Read before Hillsboro County Medical Society by the late Dr. Henry E. McMurray, on his last appearance at the Society.

etc., should be instituted at this period. Proper nutrition, the biggest problem in pediatrics, should begin on the child's natal day and be adequately supervised up to and through the seventh year at least. Malnutrition, now so common in many of the grammar schools, and is not all among the indigent and distressed poor by any means, speaks all too eloquently of the sad neglect of these innocent ones. Aside from the severe gastro-intestinal disturbances formerly so prevalent in early life and now fast receding, thanks in great part to control of milk, water, and food supplies by public and voluntary personal measures, there is, at times, a train of vague and manifold symptoms prevalent among children due to vitamin and mineral salt deficiency. In order for adequate growth to take place and increased resistance to disease obtained, a diet is necessary that is ample in quantity, proper in quality and fully balanced in all factors that make for health. Proper time for meals, adequate time in consuming them, insistence upon mastication, all should be stressed. Good sanitation in the home and school demand our attention. The long train of diseases dependent upon the lack of or insufficient measures as outlined above, once developed or developing and unarrested, can but handicap the child oftentimes for life, and means later adopted for their correction can but give indifferent results at best. The mental hygiene of the child at this time is certainly of more than passing interest. Many of the psychopathis, the emotional instabilities, the complexes, the social maladjustments seen in adults, have their origin in early childhood. And if we are to correct these properly if at all, certainly the time is when they first appear. An eminent prelate is quoted as saying: "Give me a child until he is seven years old and I care not who has him afterward." Referring, of course, to his religious training. We may equally and aptly say, give a child the proper training, care, supervision, and follow-up oversight for the first seven years and we, too, care not who has him afterwards.

With this exposition of the case for the preschool child, applying the problem locally, we may ask what is Tampa doing for him at present? What is Tampa doing for his older, grammar school, brother or sister? Formerly, medical supervision of the children of grammar and above grade age was practiced by the municipality. A physician and a corps of nurses were employed for that purpose. These no longer function. In great part the city health department functions along lines of prophylaxis. It guards the community against impure milk, water, and food supplies, and administers prophylactic treatment against certain diseases. It, too, protects the community life against outbreaks of epidemics. Most of these measures very properly come within the province of community or so-called state medicine. But the problem of the full care of the child transcends the limits and the authority of such delegated officials or public health system. Who, then, shall take up the burden, which if undone, may bring us face to face with public health authorities, private organizations, or the public health examiner? The public, once fully acquainted, (and appreciation of this matter is already at high pitch), will demand and secure for itself the adequate solution of the problem. The recent examination of the some 20,000 school, (not pre-school) children in this city by some nine physicians, covering a period of about six weeks, shows 27,000 defects noted and recorded —an average of one and a third defects approximately per child, ranging in importance from minor to fatal. In the writer's own experience, out of a total of 2,700-odd examined, only four perfect mouths were found. In one school alone, out of a total enrollment of 459, more than 110 needed dental attention, many of whom had putrid gums and teeth. And in passing, be it said to the credit of the teachers and parents of this school, 102 had gotten the necessary dental attention within two months from the time such examination was made, and many more had other defects corrected or in process of correction. In a recent examination of pre-school children for two of the grammar schools above referred to, not one child would reach the blue ribbon classification. Thanks to their parents, however, but very few defects of a serious nature were found.

We repeat then, whose duty is it to render this service? Obviously not the public health officials, for properly their field is limited to prophylaxis and that narrowed within certain well defined limits. Whose, logically, can it be? Whose must it be? The medical profession's. Who can best give this service? The medical profession. And more particularly the general practitioner. In Tampa there are 10,000 to 15,000 children from 2 to 7 years of age, one-tenth the population of the city including the outlying suburbs. What an opportunity! In this age of specialism, especially in

large urban communities, the general practitioners are all too few in number. The "family" doctor bids fair to become extinct as the dodo, if present tendencies to specialism continue. The pediatrists could not and would not attempt, alone, the responsibility nor would they, so few in number, wish to take from the general practitioner this public duty and means of livelihood. But it is upon these men that the initiative more properly devolves. Shall we meet it?

Child health is vital. The problem is far-reaching in its sociologic, biologic, and economic aspects. Health is a commodity that lends itself to sale as much so as any other. We violate no principle of ethics or morals if we attempt to sell this idea to the public. And the public will pay for such service if it be worth the price. And when we stress, that investment in health yields the largest dividends of any, and give these dividends, the public will respond beyond our hopes.

But even the private practitioner cannot include in his activities all that must be done to solve this problem. The protection of the community along health lines is a community problem, and the community, for safety's sake, must be vitally interested and supply the ways and means to this end. Despite the fact that the state of Florida appropriated only one-fourth mill for public health activities and has recently debudgeted this meager allowance, seriously hampering the board's activities; despite the fact that the State Legislature appropriated one hundred thousand dollars for the erection of a laboratory for the manufacture of hog serum to be supplied in many cases for the asking, while no longer can anti-tetanic serum for prophylactic purposes be obtained from state laboratories—a most niggardly policy—yet does that excuse the community from its just and decent obligation to a portion of its citizenry?

There is no excuse for Tampa not having special paid physicians who shall examine the pre-school and school children, and the compensation provided adequate for the type of service rendered, comparable with men in other lines of similar ability. These may be part or full time men. But the best service perhaps will be secured by full time employment, for much remains to be done outside the examining room. The compensation should be sufficient to attract men of competence. We pay some of our health officials handsome salaries, while they are free to compete with their professional brothers. We perhaps can prune with great advantage one or two city health officials. We pay our mayor a handsome salary, while he is free to devote a large part of his time to private business. This is said in no spirit of personal offense, but our system is wrong. Some of our city officials get more compensation in salary than either the governor of Texas or North Carolina, while the mayor of one of our large southern cities gets $4,000 annually. Our school system, too, is top heavy with unnecessary officials and expenditures. And if it be true that Florida expends 2¼ times as much per capita as Georgia, with a school population almost three times as large, why the shortage in finances that teachers of Tampa gratuitously donate their services for the latter part of the final month? If the budget committee of the past legislature can persuade the fee officers of the county to disgorge to the tune of $45,000-odd dollars to be refunded to the county treasury, may we not hope that when a similar audit of the several schools is made, a modest sum will have been saved, that will in part, provide for adequate school supervision of the pre-school and grammar school children? If capable officials and watch-dogs of the treasury are chosen, who are health conscious, we may avoid the loss of $30,000 sustained for repairs of Hillsboro High School three years after the building was turned over to the trustees for acceptance. In this era of depression and the cry for economy, is it too much to expect that the parents, teachers, citizens and all well-wishers of the pre-school and the school child, (for the latter needs such services sorely, too), will rightfuly and emphatically demand that these services be given, and that the birthright of these who are to become the men and women, the fathers and parents of future children themselves, be not denied them? He cannot speak and act for himself. Would we give the future citizen less? Shall we give him nothing? We predict that in common decency such a heritage will be his, for it is no less than our common and ordinary duty:

"You talk of your breed of cattle,
You plan for a higher strain,
You double the food of the pasture,
You heap up the measure of grain;
You draw on the wits of the nation,
To better the barn and the pen;
But what are you doing, my brothers,
To better the breed of men?"

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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ARE OUR SOCIETY MEETINGS INTERESTING?

There is a great deal being said and done in some of our component societies to stimulate interest among the more or less indifferent members in the medical society meetings.

There is one society in particular that is putting out a great deal of effort in this endeavor and to try to gain the proper point of view, a questionnaire was mailed to the members of that society. We feel that some of the answers to the question: "Suggest some way to stimulate interest in the meetings," will be of interest to the readers of this Journal.

These answers are listed below without comment.

1. *Everyone stop mud-slinging.* How many doctors can you count who have not told you some dirt about one or more others?

2. Let every member be ready and willing to do a little or big job in the society and let every office-holder do his job or get out. Repeatedly, members refuse to serve and, continually, certain officers and appointees begrudge their least effort or refrain from taking any initiative, even though so empowered by their office.

3. *Arrange scientific programs which may be stimulating, instructive, or encouraging* in diagnosis, treatment, or prognosis to at least a substantial minority of those doctors present. Many of the papers present some phenomenon which one physician in twenty-five will see once in fifty years. Others infer some mystic or secret discovery or endowment, the benefits of which other doctors will receive by referring their patients to the speaker.

4. Encourage plain speaking and candor. If you disagree with a man, say so and say it strongly.

5. Do not allow meetings to drag. Let papers be short and to the point.

6. Arrange more social gatherings.

7. Have symposiums on medical subjects of interest.

8. Give everyone something to do.

9. The main reason why we have the medical society is to enable the doctors to become known to one another. This is conducive to a feeling which brings cooperation. Cooperation is necessary, if we are to attain the maximum of good for the community. Therefore, become acquainted with your brothers.

10. Shorten papers. Once in a while, only, is a man so gifted that he can stand up and talk for a long time and make a crowd like it. A paper may be a gem of purest ray, worthy to be read before the highest of the high; still, if it is read before a group of doctors, who are more or less weary, each one of whom has his own particular reasons for not enjoying perfect mental tranquility, and this reading takes a long time, it will be enjoyed by a very few. The others will rub the varnish off the chair bottoms, and sigh with relief when the infliction is over.

We feel that a number of our societies might study these suggestions and obtain help therefrom.

STATE NEWS ITEMS

Drs. Earl MacCordy and Leroy Wylie of St. Petersburg spent a very interesting month in Boston, Mass., visiting the Lahey Clinic and other hospitals.

* * *

Dr. and Mrs. E. J. Hall, Miami, have returned from an extensive motor trip through the North and Canada. Dr. Hall took work at the Mayo Clinic, Rochester, Minn., and a short course at Northwestern University, Chicago.

* * *

Dr. Walter D. Webb of Boca Grande was a recent visitor in St. Augustine.

* * *

Dr. E. Sterling Nichol and family of Miami spent a two months' vacation in the North this summer. Dr. Nichol did special work in New York hospitals and clinics during this time.

* * *

Dr. Hugh West, DeLand, recently addressed the DeLand Rotary Club. He spoke on the advantages offered in Vienna, Austria, for advanced medical and surgical study.

* * *

Dr. and Mrs. Samuel Puleston, Sanford, have returned from Ft. Myers, where they spent considerable time during the month of October.

* * *

Dr. A. Lustgarten has returned to Miami from a vacation trip of four weeks.

* * *

Dr. and Mrs. Lawrence Simcox, St. Petersburg, spent their vacation this summer in the New England states.

* * *

Dr. Jack Halton, Sarasota, has been selected as a member of the state-wide committee on child welfare of the Florida department of the American Legion.

* * *

Dr. A. W. Knox, Sanford, attended the meeting of the Clinical Congress of the American College of Surgeons held in St. Louis in October.

* * *

Dr. and Mrs. L. B. Mitchell of Tampa spent their October vacation in New York.

* * *

Dr. and Mrs. Elmo D. French have returned to Miami from a visit to Chicago and the Pacific coast.

Dr. Henry C. Dozier, Ocala, made a trip to New York City the latter part of October and on his return, attended the convention of Seaboard Surgeons held in Washington, D. C.

* * *

Dr. Maximilian Stern of DeLand was a guest speaker at the semi-annual meeting of the Georgia Urological Association, recently held in Americus, Ga. His subject was: "Transurethral Prostatic Resection—Its Present Status and Its Future."

* * *

Dr. R. R. Duke of Tampa attended the annual Clinical Congress of the American College of Surgeons held in St. Louis in October.

* * *

Drs. C. D. Christ, Orlando; J. M. Dell, Gainesville; R. O. Lyell, Miami; L. S. Oppenheimer, Tampa, and J. R. Simpson, Miami, were among those in attendance at the convention of the Seaboard Surgeons, held in Washington, D. C., the latter part of October.

* * *

Dr. H. V. Weems of Sebring was the principal speaker at a recent meeting of the Sebring Rotarians. He spoke on general public health matters.

* * *

Dr. and Mrs. Michael Price DeBoe of Miami have returned from a vacation spent in Washington and Virginia.

* * *

Dr. John G. Lester, Lakeland, has returned from New York where he spent several months at the New York Post-Graduate Medical School and Hospital doing special work in urology.

* * *

Dr. and Mrs. G. D. Conger of Miami announce the birth of a daughter, Laurie Elizabeth, October 29th.

* * *

At the request of the Broward County Medical Society, the Executive Committee of the State Association has designated May 1st to 3rd, 1933, as the time of the sixtieth annual meeting, which is to be held at Hollywood.

* * *

Dr. Walter A. Weed of Lakeland, who has spent about seven months of the past year in post-graduate study at several eastern hospitals, recently returned from New York.

Dr. R. H. Knowlton and family of St. Petersburg spent the month of August in Highlands, N. C. Before returning home, Dr. Knowlton visited in New York City where he did post-graduate work.

* * *

Dr. and Mrs. A. B. Wilber, Palm Beach, spent some time in Detroit, Michigan, during the month of October.

* * *

Dr. J. N. McLane of Pensacola attended the Clinical Congress of the American College of Surgeons held in St. Louis during the month of October.

* * *

Dr. and Mrs. Samuel D. W. Light have returned to Miami from Hendersonville, N. C., where they spent the summer at their mountain home.

* * *

Dr. and Mrs. Edwin H. Andrews of Gainesville spent some time during the month of October at Indianapolis, Ind. While in that city, Dr. Andrews attended the International Medical Association meeting.

* * *

Dr. E. Gordon Fletcher of St. Augustine has been elected president of the local Kiwanis Club.

* * *

Dr. J. K. Johnston, Tallahassee, was the principal speaker at a recent meeting of the Tallahassee Rotary Club.

* * *

Dr. W. C. Person of Orlando recently celebrated his 87th birthday. Dr. Person, for many years a member of this Association, was voted honorary membership at the annual meeting in 1931.

* * *

Dr. and Mrs. John T. Bowen of Clearwater spent several weeks this summer at Corbett, N. Y.

* * *

Dr. C. A. Clemmer of Daytona Beach spent a two weeks' vacation during the month of October in Richmond and Staunton, Va.

* * *

Dr. B. E. Miller, New Smyrna, spent a ten days' vacation in the southern part of the state last month.

* * *

Dr. L. W. Martin of Sebring spent the latter part of October at the Mayo Clinic, Rochester, Minn. While in that city, he also attended the Inactive Duty Medical Reserve Officers' Unit.

Dr. M. H. DePass, Gainesville, spent the month of September in the New England states and Canada.

* * *

Dr. and Mrs. E. S. Couric of Miami announce the birth of a son, October 12th, at the Victoria Hospital.

* * *

Dr. G. C. Tillman of Gainesville attended the annual convention and clinic of the American College of Surgeons, held in St. Louis in October.

* * *

Dr. and Mrs. A. M. C. Jobson have returned to Tampa from a two weeks' visit in New Orleans where Dr. Jobson took post-graduate work at Tulane University.

* * *

Dr. and Mrs. C. H. Murphy, Bartow, spent the month of October vacationing in the North and in Canada. On his return trip, Dr. Murphy attended the five-day session of the International Medical Association held at Indianapolis, Ind.

* * *

Dr. R. R. Duke, Tampa, attended the clinical congress of the American College of Surgeons, held in St. Louis in October.

* * *

Dr. and Mrs. J. W. Smith have returned to Miami, following a visit in Philadelphia and Washington.

* * *

Dr. A. M. Sample, Jr., Jacksonville, left recently for Philadelphia, where he entered the Graduate School of Medicine of the University of Pennsylvania for two years' post-graduate work in general surgery.

* * *

Drs. J. Robert Simpson and Kenneth Phillips of Miami attended the convention of Seaboard Surgeons held in Washington, D. C., the latter part of October. Dr. Simpson is president of the organization.

* * *

Dr. L. M. Gable recently returned to St. Petersburg after a month's vacation spent in the North. Dr. Gable took post-graduate work at the Polyclinic in New York and at Dr. Crile's Clinic in Cleveland.

* * *

Dr. Geo. M. Green of Daytona Beach addressed the members of the Lenox Pre-School P.-T. A. recently. He spoke on "Helping Mothers and Babies."

Dr. Wm. E. Morgan of Tarpon Springs left for Chicago recently, where he will visit for several months.

* * *

Dr. and Mrs. L. T. Furlow of Brooksville spent some time in St. Louis and Atlanta during the month of October. Dr. Furlow attended the meeting of the American College of Surgeons while in St. Louis.

* * *

Dr. James M. Hoffman and family of Pensacola visited relatives in New Orleans recently.

* * *

Dr. and Mrs. John F. Wilson of Lakeland spent some time in Miami recently, where they visited their daughter, Miss Frances Murray Wilson.

* * *

Dr. T. F. Jackson of Dade City made a brief visit to Atlanta the latter part of October.

* * *

Dr. J. Maxey Dell of Gainesville left for Baltimore the latter part of October to attend several X-ray clinics and to do special work in this line.

* * *

Dr. S. B. Strong, formerly of Havana, Cuba, has moved to Panama City, where he will be in charge of the surgical work at the new Whitfield-Fraser Hospital.

* * *

Dr. Harold D. Van Schaick, Jacksonville, presented a paper on "Fractures of the Spine" at the recent meeting of the Seaboard Air Line Surgeons, held in Washington, D. C.

* * *

Dr. Roy Howe, Daytona Beach, recently addressed a first aid class in the life-guard headquarters. He discussed the diagnosis of heat exhaustion, apoplexy, sunstroke, fainting and suffocation and the methods of distinguishing them.

* * *

Dr. and Mrs. Norval M. Marr of St. Petersburg, spent some time this summer vacationing in Europe. Dr. Marr took post-graduate work in internal medicine in Vienna and other European clinics.

* * *

Dr. and Mrs. Alvin L. Mills of St. Petersburg recently returned from a six weeks' vacation in the North. Dr. Mills attended urological clinics in Ann Arbor, Mich., Cincinnati, Ohio, and Charlotte, N. C.

Dr. G. Walter Potter and son, Sam, St. Augustine, spent a vacation in the North during the month of October.

* * *

Dr. E. Clay Shaw of Miami spent several weeks in New York during September.

* * *

Dr. B. L. White of St. Petersburg recently purchased the 35-room Pillet Hotel on Central Avenue and 21st St. in that city.

* * *

Dr. and Mrs. R. H. Williams of Eustis have returned from a visit with relatives in Tarentum, Pa.

* * *

Dr. and Mrs. David Mills of Zephyrhills have moved from their former home to the Blair residence on Eighth St. So.

* * *

Dr. H. E. White of St. Augustine spent a week's time in New York during October.

* * *

Dr. and Mrs. Joseph Lucinian and son of Miami have returned from a vacation of several weeks in Waynesville, N. C.

* * *

Dr. and Mrs. Carl Williams of St. Petersburg spent several months in Connecticut this summer.

* * *

Dr. Gerry R. Holden and Dr. S. E. Driskell, Jacksonville, were in Tampa recently, conferring with Dr. W. M. Rowlett, secretary of the State Board of Medical Examiners, and Dr. O. O. Feaster, chairman of the Executive Committee, on Association matters.

* * *

Dr. W. H. Watters, who spent the summer in Boston, has returned to Coconut Grove, where he is medical director of the Boston-Miami Clinic.

* * *

Dr. A. K. Wilson of Jacksonville attended the Clinical Congress of the American College of Surgeons, held in St. Louis in October.

* * *

Dr. Maurice E. Heck, who summers in Bushkill, Pa., has returned to Miami. His address is now: 216 N. E. 2nd Ave.

* * *

Dr. and Mrs. J. D. Parker of Stuart were recent visitors in Ft. Pierce.

* * *

Dr. and Mrs. H. K. Murphy of Mulberry spent a vacation in Washington during the month of October.

Dr. H. G. Holland of Leesburg attended the International Medical Assembly held in Indianapolis the latter part of October.

* * *

Dr. Ernest Milam, Jacksonville, was elected district governor at the State Convention of Florida Kiwanians, held in Orlando recently.

* * *

At a recent meeting in Chicago, the directors of Alpha Omega Alpha Honorary Medical Scholarship Society adopted the following resolutions in recognition of the eminent services of the late Dr. William W. Root, Slaterville Springs, New York, the founder of the society and secretary-treasurer since its organization in 1902:

1. That all stationery and official documents of the society bear the words, "Founded by William W. Root, 1902", and

2. That the annual lecture presented each year by a leading medical scientist be known as the "William W. Root Alpha Omega Alpha Lecture."

The present officers of the society are Walter L. Bierring, Des Moines, president; Austin A. Hayden, Chicago, vice-president; Josiah J. Moore, 55 East Washington St., Chicago, secretary-treasurer. Mrs. Root will continue as assistant secretary.

The Committee on extension and policy comprises Elias P. Lyon, Minneapolis, chairman; William Pepper, Philadelphia; Irving S. Cutter, Chicago; Frederick C. Waite, Cleveland, and Thomas C. Routley, Toronto.

* * *

Dr. W. C. Thomas of Gainesville has returned from a trip to St. Louis, where he attended the annual convention of the Clinical Congress of the American College of Surgeons.

* * *

Dr. Arthur H. Weiland of Coral Gables was the principal speaker at a meeting of the Miami post of the American Legion and its auxiliary held October 28th. Dr. Weiland described the work of the state crippled children's commission of which he and Dr. J. T. Westermann are members.

* * *

Dr. J. A. Mease of Dunedin recently opened offices in the Coachman building, which is located at Fort Harrison avenue and Cleveland street.

* * *

Dr. and Mrs. R. E. Wilhoyte of Lake Wales spent a week in Washington, D. C., during the month of October.

Dr. Ralph N. Greene, Jacksonville, was the principal speaker at the Twelve-Fifteen Club recently. Dr. Greene spoke on "The Intensity of Living in the United States Today."

* * *

Dr. Gerry R. Holden, president of the State Association, and Dr. Henry Hanson, State Health Officer, were guest speakers at the Escambia County Medical Society, Saturday, October 15th, at Pensacola.

D. M. ADAMS

Dr. D. M. Adams, beloved pioneer physician of Bay county, passed away at the Frezier-Ellis Hospital in Dothan, Sunday evening, July 17.

Besides his wife, Mrs. Bannie Adams, he is survived by two sons, D. M. Adams, a student of Tulane University, and Powell Adams, a student of the University of Florida.

Dr. Adams was born in Eufaula, Ala., December 25, 1879, and came to Panama City about 25 years ago, where he has made his home and has been engaged in the practice of medicine ever since. Eight years ago he established the hospital that bears his name. He gradually worked his way into the hearts of all. He served in the Spanish-American War and also the World War.

Doctors who wish a place on the scientific program of the annual convention, to be held at Hollywood next spring, are requested to communicate with Dr. L. M. Anderson, chairman of the Committee on Scientific Work, Box 81, Jacksonville. Each request for a place on the program should be accompanied by a synopsis of the proposed paper.

* * *

The program of the Public Relations Committee is in full swing. Station WRUF, Gainesville, has granted the Association a fifteen-minute broadcasting period every other Sunday, at 2:15 p. m. As this Journal goes to press, the following broadcasts have been made:

October 16th—"Man's Place in Nature."

November 6th—"Medicine and Superstition."

The next two broadcasts scheduled are:

November 20th—"Smallpox."

December 4th—"Pasteur."

The newspaper releases for the months of September and October met with a better response from editors than was anticipated in view of the lack of interest shown by newspapers last year. The following articles have been released:

September 29th—"Childhood Feeding Habits."

October 28th—"Food Demands of Children."

TEXAN wants to move to Florida. Capable in radiography, radio-therapy and urology. Best of references can be given. Partnership or salary will be accepted. H. L. Wilder, M.D., McKean Clinic, 402-412 West Frances St., Pampa, Texas.

COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

At the October meeting of the Broward County Medical Society, plans were discussed for the formation of a Tri-County Mosquito Control organization. Dr. R. H. Stovall of Ft. Lauderdale, presided at the meeting, which was attended by doctors, citizens of various county communities and engineers familiar with the control requirements in the area. Dr. Stovall appointed a committee of seven, headed by Dr. B. F. Butler of Hollywood to further the plans which had been discussed.

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was called to order in the Huntington Building Club Rooms at 8:30 p. m., September 2nd, by Dr. Roche. The minutes of the August meeting were read and approved.

The scientific program was exceedingly interesting and elicited lively discussion. Dr. M. C. Wilson reviewed a case of triplets, with which X-ray films were shown. There were three placentae like three fried eggs in a pan. Dr. Wilson's principal presentation for the evening related to five very interesting cases of placenta previa. Discussions followed by Drs. Homer Pearson, Mary Freeman, R. N. Burch, and Dr. Wilson.

The second speaker of the evening was Dr. Bascom Palmer, who presented a paper on "Squint—Medical and Surgical Consideration." The excellence of the paper was indicated by the diversified and general discussion which it caused.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

De Soto-Hardee-Highlands County Medical Society met in Bowling Green, October 11, at 8 p. m. After dinner, Dr. R. L. Cline, of Lakeland, read a paper on "The Newest Developments in the Treatment of Asthma," discussed by Drs. C. H. Kirkpatrick, and B. D. Spears. Following this paper, several very interesting case reports were presented.

A telegram was read from Dr. Herman Watson, of Lakeland, inviting members of De Soto-Hardee-Highlands County Medical Society to

attend Polk County Medical Society meeting in Bartow, October 12.

Members present: Drs. C. H. Kirkpatrick, W. S. Pyatt, M. C. Kayton, G. S. McKnight, B. D. Spears, and L. W. Martin.

(Signed) L. W. Martin, Sec'y.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held at Monticello, October 28th. Dr. W. W. Massey, Quincy, presided. Papers were presented by Drs. R. F. Godard, Quincy; B. A. Wilkerson, Tallahassee; Ernest Wahl, Thomasville, Ga., and Roy Hill, Thomasville, Ga.

ORANGE COUNTY MEDICAL SOCIETY

A special meeting of the Orange County Medical Society, to which the various health officers of the state and members of the Florida Medical Association had been invited, was called to order by Dr. G. S. Osincup, president of the society, at 8:30 p. m., October 8th, in the San Juan Hotel, Orlando. Seventy doctors from various parts of the state were present.

Dr. G. H. Edwards, Orlando, opened the discussion by reading a paper in which was pointed out the fact that in some quarters it was felt that the State Board of Health was tending to take work away from local physicians. Dr. H. Mason Smith of Tampa, president of the State Board of Health, read a paper on the work of that organization. This was followed by a few remarks by Dr. L. M. Anderson, Lake City. Dr. Henry Hanson, State Health Officer, read a paper outlining the detail of the work of his department. The discussion was opened by Dr. Gerry R. Holden, president of the Florida Medical Association, and was actively taken up by Drs. H. C. Dozier, Ocala; C. D. Christ, Orlando; Leland F. Carlton, Tampa; H. A. Day, Orlando; W. M. Davis, St. Petersburg; J. Ralston Wells, Daytona Beach; H. Mason Smith, Tampa; A. M. Bidwell, Tampa; Joseph Rutter, Daytona Beach; J. M. Irvin, St. Augustine; Henry Hanson, Jacksonville, and Jack Halton, Sarasota.

Dr. Irwin moved that the president of the State Association appoint a committee to discuss with the State Board of Health plans by which there would be more complete cooperation and coordination of the activities of the two organizations. This motion was seconded and carried. President Holden appointed the following committee: Leland F. Carlton, chairman; H. C. Dozier, and J. M. Irwin.

The doctors of Orlando and Orange County assembled in the lounge of the Orange General Hospital Wednesday evening, the 19th, for their regular October meeting, Dr. G. S. Osincup, president, in the chair. Somewhat lengthy minutes were read and approved. Dr. Louis C. Orr read a very interesting paper on "The Transurethral Resection of the Prostate" and from the percentage of grey and bald heads in the group, it might be stated that this was a most timely paper. The discussion was active.

A letter from the Parent-Teachers' Association was received requesting the assistance of the doctors for their pre-school clinic. This brought up much active discussion because of the stand taken by the County Society to discontinue taking any part in these hit and miss group examinations of school children. The doctors waste their time because the examinations are hasty and extremely superficial; very few of those being examined receive any benefit and the breasts of the P. T. A. members and the individual parents are filled with false security. Following much active discussion, in which probably every member took part, it was voted that the children be (1) advised by the Parent-Teachers' Association to go to their family physician and that (2) the examinations should be made at the office individually and not en masse and that (3) a fee of $2.00 should be demanded, this fee covering a complete physical examination of blood, urine, etc., or whatever may be deemed necessary. That, it was felt, would result in the individual getting a worthwhile examination and the doctors not subscribing to unscientific group examinations.

A committee composed of G. H. Edwards, chairman, Hewitt Johnston and C. D. Christ, members, was appointed to investigate the relation between the Florida Medical Association and the State Board of Health and confer with Dr. Leland Carlton of Tampa.

A committee was appointed to confer with the attorney for the State Medical Association in an effort to elucidate the status of the physician (a) when he is summoned (b) the type of testimony as to fact or expert which he may be compelled to give; (c) the remuneration which he may with justice demand for such services.

A committee composed of H. A. Day, chairman, C. D. Hoffmann and F. D. Gray, members, was appointed to complete plans for the

usual winter broadcast of the Orange County Medical Society over WBDO.

(Signed) G. H. Edwards.

PINELLAS COUNTY MEDICAL SOCIETY

The first meeting of the 1932-33 year of the Pinellas County Medical Society was held October 6th, with forty members present.

Some days prior to this first meeting, five of the past-presidents composing the Nominating Committee met and selected three candidates for each office, this in accordance with the new By-Laws. Heretofore candidates were nominated entirely from the floor. By ballots the following men were elected to the various offices:

President, Dr. George E. Miller, St. Petersburg.
First Vice-Pres., Dr. M. A. Nickle, Clearwater.
Second Vice-Pres., Dr. J. A. Strickland, St. Petersburg.
Secretary, Dr. Alvin L. Mills, St. Petersburg.
Treasurer, Dr. W. C. McConnell, St. Petersburg.

Under the new By-Laws, the collection of dues has been delegated to the treasurer, instead of the secretary, as heretofore.

It was voted by the Society that the dues for St. Petersburg members should be $15.00 and up-county members $13.00.

A motion was also passed that the Society hold one meeting a month (the first Friday) and such called meetings as the president or Program Committee consider advisable. Meetings will be held in Assembly Room, Power & Light Bldg., at 8 p. m.

At a meeting of the officers of the Society held Oct. 12th the President appointed the following Standing Committees: Nominating, Dr. Leroy Wylie, Chairman; Program and Scientific, Dr. Prescott LeBreton, Chairman; Public Health and Legislation, Dr. William Davis, Chairman; Necrology, Dr. John Hardenbergh, Chairman; Social, Dr. John Herring, Chairman.

(Signed) Alvin L. Mills, Sec'y.

POLK COUNTY MEDICAL SOCIETY

The Bartow General hospital entertained the Polk County Medical Society at 7 p. m., October 12th.

Following a light repast, the doctors held a very interesting business meeting. The evening was enjoyed by all who attended. The following doctors were present:

H. Mason Smith, Leland F. Carlton, Tampa; J. W. Alsobrook, Plant City; J. W. Vaughn, Herman Watson, J. R. Boulware, Jr., W. L. Tillis, S. A. Clark, R. L. Cline, Samuel Smith, R. R. Sullivan, D. Paul Bird, Lakeland; T. G. Simmons, C. C. Deal, Auburndale; W. T. Simpson, R. H. Mooty, Waldo Horton, Winter Haven; Peter W. Besenbruch, Haines City; H. K. Murphy, Mulberry; R. E. Wilhoyt, Lake Wales; H. B. Cordes, Frostproof; Stephen Gyland, Brewster; G. H. Carefoot, S. A. Lindsey, E. L. Williams, Fort Meade; J. G. Gilchrist, J. L. Hargrove, R. L. Hughes, E. R. McMurray, C. H. Murphy, H. P. Newman, Bartow.

SARASOTA COUNTY MEDICAL SOCIETY

Sixteen physicians and invited dentists were present at the regular monthly meeting of the Sarasota County Medical Society held October 18th at the Beach club. Dr. Jack Halton, president, was in the chair.

The session was featured by the presentation of scientific papers by Dr. C. A. Andrews and Dr. Mills, both of Tampa. Dinner was served at 8 o'clock.

Visiting physicians were Dr. Frank C. Metzger, of Tampa, formerly of Sarasota, and Dr. Mills and Dr. C. A. Andrews, also of Tampa. Local physicians and dentists included Dr. S. Paul Sanders, Dr. Joe C. Landess, Dr. T. L. Ketchersid, Dr. W. H. Bond, Dr. C. B. Wilson, Dr. J. C. Patterson, Dr. T. W. Taylor, Dr. David R. Kennedy, Dr. A. O. Morton, Dr. O. H. Cribbins, Dr. J. E. Harris, Dr. W. J. Johnston, and Dr. Jack Halton.

VOLUSIA COUNTY MEDICAL SOCIETY

The Volusia County Medical Society met in regular session at the Halifax Hospital, October 11th, with 23 members in attendance. This was the first meeting since the society adjourned for the summer on May 10th.

State Medicine came in for a good deal of discussion at this meeting, as did clinics by lay organizations which sought the services of physicians. A committee was appointed by the president, Dr. J. E. Taylor, to give a paper on the subjects under discussion at the November meeting of the society, at which time members of neighboring societies would be invited to be present. Dr. J. Ralston Wells was appointed chairman of this committee, with the following as members: Drs. M. J. Myres, L. B. Bouchelle, J. E. Rawlings, Maximilian Stern, J. Davis Forster, J. N. Fogarty, and Hugh West.

WOMAN'S AUXILIARY

TO THE

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Mrs. S. E. Driskell

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Jacksonville, Florida

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MRS. WALTER JACKSON FREEMAN

It is with genuine regret that we announce the death of Mrs. Walter Jackson Freeman who recently became president of the American Medical Auxiliary. Surely the national organization has sustained a great loss.

Mrs. L. F. Robinson, president, called a meeting of the State Auxiliary Executive Board to be held in Jacksonville on October twenty-eighth at the same time as the meeting of the East Coast Medical Association.

Those attending, besides the president, were Mrs. E. G. Peek, president-elect; Mrs. E. W. Veal, secretary-treasurer; Mrs. W. W. Kirk, finance chairman; Mrs. J. R. Wells, chairman of public relations, and Mrs. S. E. Driskell, chairman of press and publicity.

Mrs. Veal was hostess at a delightful luncheon after which the board met in session. Every phase of the work was discussed and plans made for a greater organization.

Mrs. Peek was named a delegate to the Southern Medical Auxiliary to be held in Birmingham Nov. 15-18.

The Board sent a telegram of condolence to relatives and friends of the late Mrs. Walter Jackson Freeman and also joined the other states in a financial contribution for a floral offering.

* * *

The Duval County Medical Auxiliary, Mrs. G. E. Beckman president, took care of the registration, at Hotel Mayflower and at the Duval County Hospital where clinics were held, of those attending the East Coast Medical Association Oct. 28-29. Mrs. Shaler Richardson, social chairman, and her committee acted as hostesses.

The Duval Medical Society entertained with a buffet supper and dance at the Mayflower Hotel on the evening of October 28.

* * *

REGISTRATION

The following ladies, all auxiliary members, registered during the East Coast meeting in Jacksonville:

Mrs. George Beckman Jacksonville
Mrs. C. A. Clemmer Daytona Beach
Mrs. S. E. Driskell Jacksonville
Mrs. H. H. Harris Jacksonville
Mrs. Gordon H. Ira Jacksonville
Mrs. Edward Jelks Jacksonville
Mrs. W. W. Kirk Jacksonville
Mrs. Ben Manhoff Jacksonville
Mrs. R. L. Miller Daytona Beach
Mrs. S. R. Norris Jacksonville
Mrs. Thomas M. Palmer Jacksonville
Mrs. Eugene Peek Ocala
Mrs. Shaler Richardson Jacksonville
Mrs. Leigh F. Robinson Fort Lauderdale
Mrs. E. W. Veal Jacksonville
Mrs. J. Ralston Wells Daytona Beach

DUVAL COUNTY AUXILIARY

The Duval County Auxiliary held its annual meeting in the assembly room of the Hotel Mayflower on the sixth of October, and the reports for the year showed constructive work done.

Mrs. Veal outlined her activities as president and a rising vote of thanks was given her in appreciation of her splendid work.

Other reports worthy of special mention was that of Hygeia, Mrs. Chilli chairman, showing a total of sixty-three subscriptions—which exceeded the quota by three, and that of Mrs. Beckman, philanthropic chairman, telling of collecting nine baskets of sample medicines and food preparations, from the doctors' offices that they did not need, and carrying them to Brewster Hospital (for colored patients) to be used in their charity work.

Mrs. Palmer, chairman of the nominating committee, presented the slate which was accepted and the following officers were elected:

President—Mrs. George E. Beckman.
Vice-President—Mrs. N. A. Upchurch.
Secretary—Mrs. Gordon H. Ira.
Treasurer—Mrs. F. L. Fort.

A general discussion followed of various phases of Auxiliary work, its ideals and possibilities. The details of the work for the coming year was left in the hands of the new executive board.

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PINELLAS COUNTY AUXILIARY

Twenty-one members of the auxiliary of the Pinellas County Medical Society enjoyed the first luncheon meeting of the season 1932-33 on Oct. 25 at the Suwannee hotel. During the luncheon hour Mrs. R. K. O'Brien entertained delightfully with piano numbers.

Following the luncheon a business session was held, Mrs. J. A. Strickland, president, presiding. Other officers are: Mrs. A. P. Roope, first vice-president; Mrs. Prescott LeBreton, second vice-president; Mrs. W. W. Harden, recording secretary; Mrs. J. Braden Quicksall, corresponding secretary, and Mrs. M. H. Stuart, treasurer.

Chairmen of committees were appointed by the president as follows: Mrs. Hugh Wade, public relations; Mrs. Francis Langley, program; Mrs. LeRoy Wylie, hospitality; Mrs. Glenn Post, Hygeia; Mrs. Alvin Mills, press.

Letters from various state chairmen were read and discussed and a twenty-minute period was devoted to a study course on medical and health laws as related to state board of health activities.

ADVERTISERS' NOTES

ORAL THERAPY IN CONGENITAL SYPHILIS

The use of Stovarsol in congenital syphilis by pediatricians abroad induced Maxwell and Glaser to investigate the value of the therapy. The results achieved in ten cases are reported in full in the Am. J. Dis. Child. 43:1461-1489, June, 1932.

In four cases the Wassermann reactions were negative when treatment was begun, but as the parents were 4+ treatment was not delayed. These cases had remained negative over a period of thirteen months when reported. The other six cases had positive Wassermann reactions. Three were reversed after the first course of treatment, two at the end of the first rest period, and the other at the end of the second course of Stovarsol therapy. The results in these infants, all under one year of age when treatment was begun, are encouraging. Children over one year of age did not respond so readily.

Other advantageous features of Stovarsol therapy in congenital syphilis in infants and children as reported are: the remedy is administered by mouth, and the patients generally show improvement in appetite, general vigor and energy.

The authors believe that Stovarsol has a definite place in the treatment for congenital syphilis. Administration must always be under the direction of the physician as toxic symptoms may appear. In the majority of cases these symptoms

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COMMERCIALISM VS. PROFESSIONALISM

Under this title the Journal of the Medical Society of New Jersey relates the story of "One of the large manufacturers of a product extensively prescribed by practicing physicians, and extensively used for that reason, was, it seems, told by the representative of a powerful drug chain organization that it must make certain concessions to 'modern merchandising methods', or else—. The first thing wanted was an extra discount. This was needed in order that the products in question might be advertised to the public. The advertising was deemed necessary in the interest of both the manufacturer and the chain organization which proposed to handle the products in question. The answer of the manufacturer was that he did not desire to advertise his products to the public. He prided himself that he advertised only to the medical profession. He felt that the public had no business prescribing for itself, even such a good product as he made.

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NEW INSULIN PUBLICATIONS

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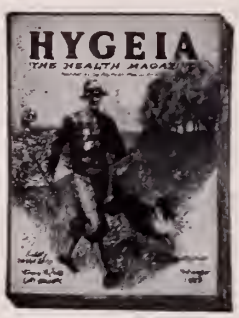
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	83%
Bay	W. J. Lee, M.D., Panama City.					63%
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		78%
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	89%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	82%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	67%
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	81%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	81%
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	89%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	80%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	91%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	86%
Madison	Geo. O. Davis, M.D., Madison.					67%
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel Bradenton	Yes.	100%
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	76%
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VOLUME XIX
NO. 6

Jacksonville, Florida, December, 1932

Yearly Subscription, $3.00
Single Copy, 30c

THE N.Y. ACADEMY
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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 28, 1924

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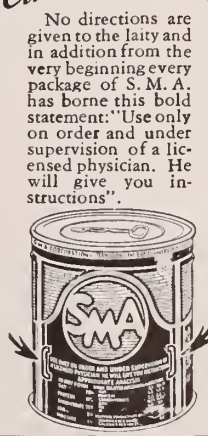
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PUBLISHED MONTHLY
Volume XIX | Jacksonville, Florida, December, 1932 | Number 6

THE MODERN TREATMENT OF SYPHILIS AND SOME OF ITS COMPLICATIONS*

FRANK WILSON, M.D.,
Jacksonville.

The purpose of this paper is not to present any new or radical ideas in the treatment of syphilis; it is to emphasize the fact that systematic treatment over a long period is necessary to effect a cure and that there are no short cuts. Even early syphilis in which the Wassermann has not become positive must be treated intensively and can not be considered cured until it has remained seronegative for a year.

The modern treatment of syphilis can be said to date from the discovery of arsphenamine by Erlich in 1910. Before that time, sole dependence had to be placed on mercury and the iodides, and it is doubtful if syphilis was ever permanently cured. It was difficult to treat a patient sufficiently with these two drugs to arrest the disease without causing injury through overdosage, and disagreeable complications were extremely likely to occur. Mercury was one of the *first* remedies to be used in the treatment of syphilis when this disease made its appearance in southern Europe in the latter part of the fifteenth century. It is the only one of the very early remedies that has stood the test of time and is still in use today. It was first used as an inunction by Berengario de Carpi and Jean de Vigo in 1497. It may be given by inunction, injection or by mouth, the intramuscular injection being the most satisfactory. It has at times become very unpopular and almost discarded on account of its disagreeable effects and the pain caused by most methods of administration, but there had never been an effective substitute until the introduction of bismuth in 1921 by Sazerac and Leviditi. Since the introduction of bismuth, mercury has again lost in favor and bids fair to be replaced entirely by the former drug which is more spirocheticidal and much less toxic and causes less pain when injected. Mercury, though still used by many syphilologists, is used by most men in the comparative rest periods between courses of arsphenamine and bismuth. The iodides, though not spirocheticidal, have a distinct place in the therapy being used in all the stages and are indispensable in cases of long standing. The peculiar property of the iodides of breaking down the fibrous capsules with which gummata are surrounded makes them of great service in freeing the enclosed spirochetes and exposing them to the action of the more powerful drugs.

These four drugs—arsphenamine and its derivatives, bismuth, mercury and the iodides—when used intelligently, will effect a cure in most cases of syphilis provided the treatment is begun early in the course of the disease and the patient is otherwise physically able to stand the treatment. Arsphenamine, far the most powerful spirocheticide yet known, falls far short of Erlich's dream of a one-dose cure, and we now realize that in spite of the great strides made in the last twenty years the length of time necessary to effect a cure has not been shortened. There has been irreparable damage done in the past through the mistaken assumption by a great number of physicians that six doses of arsphenamine constituted a cure and that one negative blood test was sufficient evidence of a cure to warrant discharging the patient.

There are several methods of treatment in common use. The first, and probably the most popular, consists of alternating the courses, that is, giving a course of arsphenamine then a course of bismuth with occasional rest periods during which mercury and the iodides are given by mouth or whatever method is chosen. The second method is to give the arsphenamine and bismuth concurrently on different days each week. The third method is the simultaneous one as used by Schamberg and Wright, who give a dose of both drugs the same day. If this method is used, the amount of each drug must be considerably smaller than when each is given separately as there seems to be a synergistic action between the two.

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

There has been a great deal of discussion as to the size of the dose of arsphenamine, some men using large ones and others advocating small ones. But it should be noted that most of the discussion centers about arsphenamine itself and not one of the milder derivatives. Thus, when a 0.3 gm. or 0.45 gm. dose is mentioned it would take a 0.45 gm. and a 0.6 gm. dose of neoarsphenamine to be equivalent as it is approximately one-third stronger. It has been my experience that giving too small doses is almost as bad as giving none at all, for small quantities of arsenic seem to have the effect of stimulating the spirochetes to activity instead of destroying them and may in addition render them arsenic resistant. It has been repeatedly observed that an active syphilide may make its appearance during or after prolonged treatment with too small doses. The amount should be regulated to suit each individual patient and should be as large as the patient can tolerate without a reaction. Neoarsphenamine can give just as good results as arsphenamine if it is remembered to use one-third more at each dose. Ordinarily, for the average adult both male and female, a dose of 0.6 gm. is both effective and well tolerated, but in the case of a person above average weight, 175 pounds or more, a 0.9 gm. dose will be required. When simultaneous treatment is used the dose should be reduced to 0.45 gm. and should never be larger than 0.6 gm. of the neosalvarsan.

The newest arsenical combines in the same molecule bismuth and arsenic and would probably be the drug of choice in all cases, except for the fact that unless very careful technique is used the pain causes violent objections by the patient. Some are able to use it without much discomfort over long periods of time but in the writer's hands it has been unsatisfactory and he has always had to go back to the intravenous route. Usually about three months is required for the first course, giving an injection of each every five days unless contraindicated, after which mercury may be used for about six weeks and the inunctions are satisfactory if the patient can be trusted to use them according to directions; otherwise intra-muscular injections will have to be used. Insoluble mercury salts as the salicylate, may be injected at seven day intervals suspended in oil, or a soluble preparation as the succinimide twice or three times a week. After six weeks the arsphenamine and bismuth course is repeated. The remainder of the year is given over to alternate courses of bismuth and mercury, about twelve of each at weekly intervals. If the Wassermann has remained persistently negative throughout the first year, the case may be considered cured but if the blood was positive after the first course another three months course should be given at the beginning of the second year. In this way thirty-six doses of neoarsphenamine, forty-eight doses of bismuth and about twenty-four doses of mercury are given in a period of a year. This is rather intensive and cannot be kept up in chronic cases which require treatment for one or two additional years. However, the bismuth is comparatively harmless and can be continued for long periods without apparent damage to the organs of the body. In some cases of hereditary syphilis or the acquired in which there is evidence of visceral involvement, bismuth may be used alone or in conjunction with the iodides and in some hands seems to prove superior to neoarsphenamine.

Since the introduction of the Wassermann there has been a tendency to treat the blood test instead of the patient and time and again the writer has seen mercury treatments continued after ptyalism had begun to develop and arsphenamine continued after the patient complained of itching and a "breaking out." A severe case of mercurial stomatitis or a severe case of arsphenamine dermatitis will cause almost any patient to stop treatment before he is well. Jaundice and peripheral neuritis, though comparatively rare, should be watched for and treatment discontinued at the first symptoms. The fact should be stressed that once a patient has developed an arsphenamine dermatitis he can never be given that drug again, for the skin develops a sensitivity to arsenic and even minute doses will cause severe dermatitis.

In the last few years, since the introduction of bismuth, there has been noticed a number of cases in which patients have developed a pigmentation sometimes accompanied by dermatitis and sometimes not. It may appear at any time, occasionally even after all treatment is stopped.

Arsphenamine dermatitis often leaves a black or brown pigment but has not the appearance of the one caused by bismuth or more likely caused by the combination of the metals. In some cases it has all the appearances of an argyria and indeed seems to be more common with bismuth and silver salvarsan than with the other arsenicals.

This pigmentation begins as a stippling and usually remains so on the tongue and mucous membranes, but in the skin, especially around the mouth and eyes, the stippling becomes confluent and is very black. This pigmentation is very resistant to any known treatment and fades out very slowly.

Sodium thiosulphate has taken a very prominent role in the treatment of syphilis in recent years. Though not a spirocheticide it will occasionally change a persistently positive Wassermann to a negative one after all other treatment has failed. It is an antidote to all the heavy metals and is the one remedy that is indicated when any of them have been used to excess. It is occasionally used prior to arsphenamine to prevent the immediate reaction and is also used to inject any extravasations of arsphenamine into the tissues as soon as possible after they occur. When using sodium thiosulphate, it is well to remember that freshly prepared solutions are far more effective than those put up in ampoules already mixed for the sulphur is evanescent and when an ampoule stands for any length of time it loses its effectiveness entirely.

In neurosyphilis triparsamid is the arsenical most commonly used and is superior to any of the arsphenamines. It is used in conjunction with bismuth and the iodides. Sometimes it arrests the disease and occasionally it produces apparent cures which are generally only remissions for it is very unusual to cure a case that has cerebrospinal involvement. When triparsamid is alternated with malarial inoculations the patient shows a gradual improvement which is sometimes remarkable and he can be kept in an apparently normal state for years. The malarial inoculations were first introduced by Wagner Janregg in 1917 and have been used with remarkable success. The procedure is to expose the patient to infected anophelene mosquitoes or to inject blood from an infected person, about ten cc. of the infected blood being injected subcutaneously in the subscapular region. The patient has the first chill in from seven to ten days. This is the beginning of a regular attack of malarial fever with chills every other day. The malarial infection is controlled by quinine after a varying number of chills according to the patient's condition. Sometimes improvement in nervous and mental symptoms is noted before the malarial fever is stopped; in others the improvement begins later. After it is thought that the improvement has ceased the inoculation may be repeated, triparsamid being used in the intervals. In this way there is some improvement in almost every case and in some the symptoms clear up entirely even after dementia has developed and the gait has become ataxic. The heat is supposed to be the cause of this benefit and there are experiments at the present time to cause fever by diathermy without subjecting the patient to the severity of the malarial infection. Another nonspecific treatment is autohemotherapy in conjunction with general ultra violet ray exposures, but as the treatment of neurosyphilis is generally conducted by a specialist in that line or in an institution it is not of general interest.

The conclusions reached by the writer based on some years of experience in the exclusive treatment of syphilis in a venereal clinic and on the writings of well known syphilographers are:

1st. That all cases of syphilis require prolonged treatment.

2nd. That no case should be discharged until it has been serologically negative for a year.

3rd. That old cases, tertiary, hereditary, neurological, etc., should be treated over a period of years regardless of serological findings.

4th. That close personal supervision should be kept over all patients, and not simply a diagnosis made and the patient turned over to a technician for some routine treatment.

DISCUSSION

Dr. Elmo D. French, Miami:

Dr. Wilson evidently had in mind in the preparation of this paper, the syphilitic patient with universally good organic function, in short, early syphilis in the otherwise healthy adult. He has pled for sustained treatment and adequate dosage.

The statistics of Moore and Keidel, of Stokes, of Cole, of O'Leary and of Wile, and of others, show conclusively that the incidence of clinical and serological cures in early syphilis is in direct ratio to the amount of arsphenamine used.

Dr. Wilson's estimate of 36 injections of 6 gm. neoarsphenamine is the minimum recommended and if he has succeeded in driving home that one idea, he has done our patients a true service.

May I be pardoned for stressing a few points not embodied in Dr. Wilson's paper?

First: That the treatment of syphilis begins only after a proven diagnosis of syphilis.

Do not allow your patients to persuade you to use caustics or antiseptics on a penile sore until all reasonable doubt of its true nature is expelled. Many a negative dark field examination has been caused by yielding to a patient's insistence that you do something at once to heal the sore.

In like manner, as Dr. Wilson has so forcibly brought out, there is no abortive treatment for syphilis; the disease must be worn out.

The idea that syphilis can be aborted by a few doses of the arsphenamines seems to have support in the advice of some authorities to give an immediate injection of arsphenamine after known exposure to contagion.

Consider first that it is impossible to prove that infection would have occurred in any event and again that infection at times does occur in spite of the prophylactic injections.

The explanation offered by some is that a tissue reaction to the spirochetes must occur before the arspehnamines will attack the spirochetes.

The bismuth preparations are generally conceded to be superior to mercury. I do not believe mercury will be abandoned in the treatment, however, because of certain obvious advantages of the inunction:

1. It is efficient as a method of treatment.
2. The toxic effect of mercury is easily controlled when given by inunction.
3. It is an inexpensive form of therapy.
4. It is a welcome relief to the patient from the injections.

Dr. J. L. Kirby-Smith, Jacksonville:

I have had the privilege of observing the work of the essayist for the past ten years and mostly agree in his statements in regard to thoroughness in the treatment of syphilis. Twenty years ago today I presented to the Florida Medical Association a report on the personal observations of the arsphenamine treatment of syphilis, and I emphasized at that time that the cure of syphilis with this heralded "606" could not be accomplished by a few injections but would require careful and systematic treatments for a period of one or more years. Since that time the European War has taken place and with it has been disseminated general information to the public in regard to the dangers of syphilis and measures of treatment.

Along with this have been developed in most communities institutions for the treatment of the disease. As a result, today, syphilis is not one of our common infections. From my experience in the treatment of skin diseases which include syphilis as a part, I would say that it is infrequent to see a beginning of the infection. But this is aside from the discussion.

For the past four or five years for the routine treatment of syphilis I use a combined neoarsphenamine bismuth, treatments given simultaneously once a week. I have given up entirely the use of mercury. For various reasons I have found it unsatisfactory. All medical men treat syphilis and the purpose of Dr. Wilson's paper is to outline a systematic measure to cope with the disease.

In closing my remarks I would emphasize that in treating this chronic blood disease you must have in view all features of the patient's health, social conditions and finances. I thank you very much.

Dr. Hubbard Gates, Bradenton:

I would like to ask Dr. Wilson one question relative to treatment: that is what he thinks of colloid mercury intravenously, also the preparations of bismuth. I understand that you can give a liquid form of bismuth intramuscularly. I would like to know what he thinks about these.

Dr. Frank Wilson, Jacksonville (concluding):

Mercury should never be used intravenously, for most forms are so irritating that they will sclerose the veins and prevent all further intravenous medication.

As to bismuth: I believe the soluble salt to be most easily assimilated and for that reason to be most effective. I use a soluble preparation called thio-bismol with very satisfactory results.

In using the simultaneous treatment a preliminary dose of bismuth should be given and several days allowed to elapse before giving the arsphenamine and bismuth on the same day. The combination will kill the spirochetes so rapidly as to cause a Herkeimer reaction in some cases. This would be dangerous if the patient had a cardiac involvement. In young patients with primary lesions it is better to begin with one or two doses of arsphenamine so as to sterilize the lesion as quickly as possible for public health reasons.

ENDOCERVICITIS*

W. J. JOHNSTON, M.D.,
Sarasota.

The title of this paper, Endocervicitis, is a broad and comprehensive one, including all types of inflammation of the lining of that portion of the uterine canal lying between the external and internal os. For convenience in studying them, they may be divided under the headings of acute endocervicitis and chronic endocervicitis.

ACUTE ENDOCERVICITIS

Little time will be spent in considering the acute type as this paper is mainly concerned with the chronic type. The acute condition, in brief, is due to infection particularly with the gonococcus or other pyogenic organisms. In gonorrheal cervicitis the inflammation is nearly always an extension from the vagina and this may constitute a termination of the infection. In other words, it may remain in check within the cervix. Ordinarily, endocervicitis caused by other organisms may follow labor or abortion but then it is usually overshadowed by the more serious inflammation of the body of the uterus, that is, septic endometritis. The pathologic changes are practically the same from either cause, except that the septic is usually accompanied by lacerations. These changes are hyperemia, swelling of the mucosa and serous and round cell infiltration with increased secretion. The symptoms are very typical, being increased discharge of an irritating character, tenacious and stringy, resembling the white of egg except that it is more jelly-like. There is an uneasy sensation of weight and discomfort in the pelvis. There is rarely pain if the inflammatory process is limited to the cervix. Upon examination, the cervix will be seen to be swollen, edematous and to bleed on slight manipulation. With these signs and symptoms, little trouble is encountered in diagnosis. It is important to distinguish by microscopic slide between the gonorrheal and simple septic type, as a guide for treatment.

Treatment: The objects of treatment are in the main: first, to prevent the extension of the inflammatory process to the body of the uterus and adnexa; second, to prevent, if possible, the extension of the infection into the deep glanular structure of the cervix; and third, to check the irritating discharge and consequent discomfort. The first necessary step is to instruct the patient to take as little exercise as possible. In many severe cases, it is probably better to put the patient at rest in bed. Applications to the cervix should be made very cautiously so as not to disturb the internal os thereby carrying infection to the body of the uterus. As to the drugs used for application, there are many differing opinions as to the most suitable one. Silver nitrate is a very popular drug for application to the interior of the cervix, in strengths of from five to ten per cent and may be used on alternate days. If the gonococcus is the causative agent, there will probably be vaginitis which must be treated concurrently. The removal of tenacious mucous should first be effected, otherwise the medication has difficulty in reaching the diseased mucosa. An effective aid for the removal of mucous is a weak solution of liquor potassae on a cotton applicator. During the early stages of acute inflammation, a permanent dressing of boroglyceryde or icthyol ten per cent in glycerine, may be used on a tampon in contact with the cervix. A thin strip of gauze saturated with either of these dressings may be gently inserted within the cervical canal. Hot antiseptic vaginal douches every four to eight hours are most efficacious, bichloride being the drug of choice for the septic types and potassium permanganate for the gonorrheal types. After the first few days when treatment has reduced the hypermia and edema, the most effective treatment in my hands has been the application of ten per cent mercurochrome within the cervical canal and to the entire vagina when necessary, followed by irradiation with the water cooled quartz lamp. So much for acute endocervicitis.

CHRONIC ENDOCERVICITIS

Chronic endocervicitis is chronic inflammation of the cervical mucosa and tissues adjacent thereto. It is known also as cervical catarrh, cystic degeneration and inflammatory hypertrophy. The chronic type usually follows acute inflammation of like character though in some cases the acute symptoms may have been so slight as to have escaped notice. The gonococcus is a common cause of endocervicitis while laceration is a fruitful source of chronic septic endocervicitis. In the latter type the cervical glands and lymph spaces are torn open, the resulting scar tissue obstructing the gland ducts, thus leading to cystic degeneration. Laceration further causes an eversion of the cervical mucosa, exposing it to friction against the vaginal wall with consequent chronic irritation.

*Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

The infecting germs penetrate the mucosa of the cervix, causing round cell infiltration of the glands and stroma tissue. There is increased secretion, the irritating discharge producing erosion and vaginal and urethral irritation. Upon examination, the cervix is ponderous, congested and the mucosa is everted.

Chronic inflammation and eversion may occur even in the virgin without laceration, in some cases giving an erroneous impression of previous pregnancy.

Papillary growths may be formed as the result of irregular thickening of the mucous membrane. These may hypertrophy to become what is known as cervical polypi. These small growths obstruct the os resulting in accumulation of discharge in the cervical canal and producing ulceration within the cervix. Another cause of ulceration within the cervix may be contraction of the external os from cicatrices, thereby retarding drainage.

The gland ducts, as previously stated, frequently become obstructed by cicatricial contraction resulting in a retention of the glandular secretion and producing cystic degeneration. Upon examination, a cervix so affected may be so honeycombed by these small cysts as to closely resemble cancer. Quite frequently the contents of the cysts become infected with pyogenic organisms, giving the appearance of a small yellow spot on the cervix.

There is considerable connective tissue proliferation as the result of chronic inflammation which accounts for the enlargement of the cervix. Later, the contraction of this inflammatory tissue results in a cirrhosis or sclerosis predisposing to cancer. The symptoms are: vaginal discharge, sense of weight and dragging in the pelvis, and backache. The diagnosis is readily made upon exposing the cervix which exhibits the typical signs of hypertrophy, erosion, eversion of the os and probably systic degeneration.

Treatment: It is with the treatment and cure of this stubborn condition that we are chiefly concerned. The usual topical applications of caustics have been very disappointing and discouraging in many cases. I venture to say that all of us have encountered many cases of this kind that have been very slow in responding to treatment and it is for this reason that a newer and more effective procedure is being presented in an attempt to reduce the percentage of intractable cases. For three years the writer has been using electro-coagulation with most gratifying results. No other method of treatment has given nearly such satisfaction in his hands. The advantages of this procedure are many, chiefly being, the rapidity, the effectiveness and permanency of the cure.

The cervix being poorly supplied with sensory nerve endings, can be treated by this method without any anesthesia, in the office without hospital expense to the patient. With the proper instruments or electrodes, it is a comparatively simple procedure. Any good high frequency apparatus suitable for coagulation may be used. The electrode of choice is one known as a bi-terminal electrode, that is both terminals end in the electrode itself. An older method which is today discarded by many was the use of an active electrode within the cervix and an indifferent electrode elsewhere on the body. With this method it was more difficult to control the depth of coagulation in the tissue, whereas with the newer bi-terminal instrument it is possible to absolutely know the depth of tissue that is cooked or coagulated. The procedure is as follows:

The bi-terminal electrode referred to is inserted the entire length of the cervical canal until it meets the resistance of the internal os. Having previously set the machine to the desired milliamperage, the active surface of the electrode is gently pressed against the posterior wall and the current turned on by a foot switch for three seconds. Then the electrode is rotated until the active surface is in contact with the right lateral wall and the current again switched on for three seconds. The anterior and left lateral wall are then treated in the same manner; or the electrode may be slowly rotated through a complete circle with the current constantly on, the time consumed in all being about twelve seconds. Either method will completely coagulate the internal surface of the canal to a depth of about two millimeters. The electrode is then removed and another, similar but furnished with sharp needle-like points, is attached to the conducting cord. We are now ready to treat the deeply infected cystic glands. The sharp points of the electrode are plunged to the full depth of the cystic gland, the current again being turned on for about a second. The procedure is repeated in as many areas as indicated. The sharp points are then replaced by ball points and we are now ready to treat the erroded surface. The ball points are placed in contact with the periphery of the erroded area and the current turned on for

about one second. This blanches or coagulates a small area. The current is then switched off, the ball points moved to an adjacent area and so the treatment is continued until the whole of the erroded surface has been coagulated. This completes the treatment and it is seldom necessary to repeat if thoroughly done at the first sitting. Very little discomfort is experienced at any time and practically no post-operative care is necessary except the daily use of a good deodorant douche. The coagulation is followed in about twenty-four hours by a copious vaginal discharge which keeps up for several days, necessitating the cleansing douche. The patient may be permitted to carry on her usual activities and it is not necessary to see her for about five or six days. At this time it will be seen that there is considerable sloughing of the destroyed tissue which is complete in about eight or nine days. From this time on healing begins and is much more rapid than one might expect. After about three weeks the erroded surface in most cases is completely covered by new epithelium. All discharge has ceased and the condition is completely cured. The only serious contraindication for this treatment is acute inflammation. The acute stage must positively be permitted to subside before coagulation is undertaken, otherwise rapid extension through the lymphatics to the tubes and the body of the uterus is almost certain.

The dangers of cicatricial contraction with stenosis are practically negligible with the method. It has a decided advantage over cautery in that cautery actually chars tissue, cannot be definitely controlled as to the depth of destruction, is more prone to produce stenosis and is more painful, necessitating anesthesia. There is no method ever observed or used by the writer which so completely cures with so little disturbance to the patient. The electrodes used may be seen after the discussion of this paper.

DISCUSSION

Dr. Blake M. Lancaster, Manatee:

It is with a feeling of pride that I am congratulating Dr. Johnston on his paper—not so much that he has told us something new about endocervicitis, but that he has had the courage to bring us a treatment which seems to be based on sound principles. I can well remember in the early part of my practice when I tried to treat leukorrhea. I had been familiar with the teachings in college regarding tampons, washing of the canal, glycerine applications and deep currettement of the cervix, but disappointment resulted after everything had been done that we were supposed to do. I went to the best consultant that I knew and asked him his treatment for endocervicitis. He apparently was also discouraged, because he said, "Boy, if you can find a treatment that will cure leukorrhea you have made your fortune." I did not hunt for it because my results were bad with any sort of treatment attempted.

Recently I have been using actual cautery, cutting through the mucous membrane of the cervix in four segments, as Dr. Johnston describes in his paper. And I think the treatment he has given us today for endocervicitis is one of remarkable value provided it is used in competent hands. I cannot speak with authority on the treatment because I have had no experience with it. But, in the voice of criticism, I should say it is laid on sound principles. Destruction of the diseased tissue and the removal of it, is the first step toward a reasonable cure.

Acute endocervicitis is a condition that is familiar to all of us, but it is chronic endocervicitis, due most probably to the colon bacillus, that upsets all our calculations and makes it difficult to treat with satisfaction the sufferer who would give anything to get relief. I think Dr. Johnston's paper was splendidly written.

Dr. W. M. Rowlett, Tampa:

Dr. Johnston has given us a splendid paper.

I consider electro-coagulation among one of the most satisfactory methods of treating endocervicitis. However, each case offers individual characteristics which precludes any one method of treatment being adapted for all. I would hardly know how to get along without my high frequency machine. In addition to the splendid work it is doing, it has proven a great boon to those suffering from a cervical infection, but who are unable to pay for hospitalization and an operation.

I shall not devote the small time allotted to me, discussing this or that treatment, but instead to an earnest plea for the poor neglected woman. If the profession will admit the truth, I can not see how it can refrain from blushing in shame. Some day she is going to wake up to the realization of the fact that her trust in us has been sadly misplaced, for which she has paid the price with ill health or death, the latter being a blessing, as compared with the suffering that some have endured.

Millions of dollars are being spent annually to educate the people as to the importance of detecting the early symptoms of tuberculosis and other infectious or contagious diseases. How many of you have ever heard of a dollar being spent to educate the woman as to where the greatest foci of infection in her body is located, and to warn her if not properly treated, it may lead to the birth of a blind baby, cancer, or the infection of her pelvic organs, necessitating a serious operation and resulting in invalidism for life? I plead with you, that when that beautiful, blushing young bride, a real specimen of young womanhood, cheeks aglow with the tint of youth and health, and who has just surrendered God's richest blessing to the man she loves, for God's sake, do not turn her away with the simple prescribing of a douche, without a painstaking examination to determine the cause of these symptoms of which we all so often hear. Be honest with her, tell her the truth, that the pain she had along with the loathsome leukorrhea, is not the result of "female trouble," as some of her friends have advised her, but instead is the result of "male trouble," or if she has borne children, the neglect of the careless physician who attended her.

Please do not think that I am posing as a reformer, however, if in my humble way I can check even in a small way the flood of this tide of neglect and arouse a sentiment that will offer a balm of relief to these poor sufferers, I shall feel that my efforts have not been in vain.

Dr. J. E. Harris, Sarasota:

I want to commend Dr. Johnston on his presentation of the subject of electro-surgical treatment of endocervicitis.

My observations over the past few years of the results of cervical lesions being treated in this manner, as described by Dr. Johnston, prompted me to use this method which gives permanent results without surgery, and little inconvenience to the patient. The final result of extensive electro-coagulation of the cervix, complicated with severe laceration does not preclude surgical repair of a cervical laceration at a later date. It is more efficacious than any other method. It does not impair function of musculature or cause cicatricial stenosis as often happens with post cautery, which is usually used by physicians not equipped with diathermy.

Under the subject of contraindications, Dr. Johnston stated that acute inflammation is the only contraindication to this method of treatment. It is true that this is the principal contraindication, but there are several contingent ones depending upon other complications which, in turn, are amenable to local or constitutional treatment.

Active lues, Vincent's infection, advanced diabetes, or any constitutional condition which might retard or prevent final healing of tissues after the coagulum sloughs or separates. Extensive anti-luetic treatment until Wassermann is negative had best precede electro-coagulation of any cervical lesion if active lues is present.

When Vincent's spirillum infection is present, the coagulum becomes very malodorous and the adjacent pelvic tissues become extensively involved, with extensive symptoms of adnexal inflammation, which may result in a general blood stream infection, and this is fatal.

A preliminary treatment with ten per cent copper sulphate and intravenous neosalvarsan should precede electro-coagulation in such a case. Several microscopic smear examinations should be made before electro-coagulation if Vincent's is suspected.

Before every electro-coagulation procedure of the cervix, a routine sugar test of the urine should be made on account of the danger of a gangrenous slough that would almost inevitably follow electro-coagulation in a diabetic patient. To the general practitioner who is equipped with diathermy equipment, the method as described in Dr. Johnston's paper will relieve a great percentage of the patients who come to his office with this pelvic trouble. There is one procedure, and only one, that is better than electro-coagulation of cervical lesions but this method cannot be performed with so-called diathermy machines. The method I speak of is that of Dr. Hyam of New York Post-Graduate Hospital. His method is known as "conization." A surgical cutting current is necessary. The difference in this method and the method as described by Dr. Johnston is that when a cutting current is used in coning out the lining of the cervix, there is little or no coagulation of tissue which may result in even a small deposit of scar tissue.

I have seen Dr. Hyam's demonstration with lantern slides which showed in a section taken from the cervix a few months after a post-cautery, an abundant deposit of scar tissue. Then, a lantern slide of a section of the cervix taken after electro-coagulation showed a very small amount of scar tissue. And then a slide of the

cervix after Hyam's method of "conization" showed the least amount of scar tissue formation.

For practical purposes, the method of electro-coagulation of cervical lesions will relieve permanently the diseased cervix with a minimum result of scar tissue formation and subsequent stenosis.

Dr. Hubbard Gates, Bradenton:

There is one question I would like to ask Dr. Johnston. From his paper he seemed to do the whole operation at one time. Or does he take one of the four sections of the cervix, and after that gets well take another quadrant? Does he destroy all of the cervix at one time with coagulation?

Dr. W. J. Johnston, Sarasota (concluding):

I wish to thank all the gentlemen who participated in the lively discussion of this paper.

Dr. Lancaster mentioned the necessity for a thorough knowledge of the powerful agent, high frequency current, before attempting this work. This is only too true. Any practitioner not thoroughly conversant with coagulating currents should observe their usage in competent hands before attempting to use them.

Dr. Harris brought out some very good points, especially regarding contraindications. Of course there are conditions of the cervix, deep lacerations that we would not consider amenable to coagulation and that must have surgical care. My observation has been that eighty to ninety per cent of cases of chronic endocervicitis that one sees in the office can be satisfactorily treated by coagulation. Vincent's infection, being more or less an acute condition, is, therefore, a contraindication. I do not believe active lues is a contraindication. Healing, of course, will be much slower as it is in the case of any other open wound in the body in the presence of luetic infection. As to diabetes, I do consider this a contraindication and believe that there should be a reduction of the sugar before coagulation is undertaken.

I have had no personal experience with Hyam's method or conization, as it is called. However, I see no reason with the good results to be expected with coagulation, why one should fit himself with other expensive equipment capable of delivering a cutting current as I am satisfied that with electro-coagulation we give equally good results. The only difference is whether you wish to cut out what you coagulate or permit it to slough out.

Dr. Gates asked the question as to whether this work was done all at once or at four sittings. It is done all at once, each sector of the canal being coagulated from two to three seconds. The electrode is simply rotated to each quadrant in turn until the surface has been completely treated. It is sometimes necessary to repeat the treatment. The longer experience one has with the method, the less often will there be necessity for repeat treatments. Particular care must be given to the destruction of the cystic glands, as failure to destroy these is usually the reason for having to repeat the treatment.

It is sometimes necessary to stimulate healing after the coagulation has been done. However, I have seen few cases that were not completely covered with new epithelium at the end of a month.

If this paper has been of service in bringing to the profession a method of treatment giving satisfactory results for this stubborn condition, I shall be amply repaid for its presentation.

PREOPERATIVE AND POSTOPERATIVE TREATMENT OF SURGICAL PATIENTS, WITHOUT COMPLICATIONS*

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There is a subject in which all who are interested in surgery are vitally concerned, and one of which, when consulted, the average man doing surgery will, in his own mind, have his own ideas, but will more or less evade answering if interrogated. This is a subject covering a large field and of intense interest because it contributes much to the success or failure of the operator. Hence, an effort is made to summarize in as concise a manner as possible the preoperative and postoperative treatment of uncomplicated surgical patients.

Every surgeon knows that the operation in itself is only a small part of the total effort on his part to effect a recovery. Often the criticism is made on the part of the patient and the family that the medical man, in his constant dealing with the ill and suffering, becomes "hard boiled" or calloused to the feelings of his patients. However, with his frankness to them of the danger and gravity of the surgical procedure, he should care-

*Read before the Escambia County Medical Society, Feb. 23, 1932.

fully guard against being too sentimental, and should guide them through with his sympathy and skill to where their confidence will be an important element in their convalescence and recovery.

A complete history of their condition with reference to all details relative to the ailment should be made and this should be followed by a thorough physical examination which should give the physician a scientific and accurate diagnosis which may be confirmed by indicated laboratory examinations and will lead to a more perfect result.

Every patient must be regarded from two standpoints, the mental and the physical, the physical being in a majority of instances more easily handled than the mental.

Postoperative complications are far too high because many surgical patients are not ill and we subject them to operation without carefully determining their possible susceptibility to infections, which are usually of the pulmonary or respiratory type. For instance, a man with a hernia may have it carefully operated upon and, because of neglect in ascertaining the presence of a respiratory infection, he develops a pulmonary complication from some simple respiratory infection which he had prior to his operation.

The nose, throat, ears, mouth, heart and circulatory system, the lungs and the urinary organs require careful study. Surgical skill alone will not suffice; it must be supplemented by surgical judgment in that the surgeon must be able to recognize changes from the normal, when present, and fully appreciate their significance. Careful heart analysis and routine examination of urine even to functional test should be strictly carried out. Twenty-five per cent of phenolsulphonephthalein excretion in two hours is the minimum for safety in operative work. A blood chemistry estimation is always necessary in severe involvement of the kidneys.

Asepsis being the aim of all surgery, it is necessary to guard against, in every possible manner, postoperative infection. The patient should be carefully prepared locally for the operation, as many of the infections arise from this faulty technic and the patient presenting a serious infection is in need of preoperative, supportive measures. The diluting of the toxemia by fluids gives striking results and blood transfusion, where the hemoglobin is low, may be a life saving measure if given prior to the operation. It is almost essential in chronic cases of osteomyelitis which exhibit a low hemoglobin content. The lowering of hemoglobin to 60% or below should be regarded as nearing the danger mark. It is evident, however, that in cases of ulcerative lesions of the gastrointestinal tract, long standing infections and the specific infectious diseases of the blood forming system, the attempts to raise the hemoglobin will be futile and that much valuable time may be lost in such attempts. In these, possibly a transfusion immediately before, with others after the operation, is indicated as supportive treatment.

All diseases of the alimentary tract require careful preparation of the patient since the chief complications are infection and obstruction, and unless the case is one of emergency the patient should have two or three hospital days prior to operation, where ulcers, malignancies, pyloric or high intestinal obstructions may be treated. Lavage should be given once or twice daily and continued until the returns are clear; and either water or saline, warmed, should be used in large quantities, if necessary. A measure which is as distinctly a preoperative as a postoperative procedure is the use of intravenous injections of 10% NACL combined with 15% glucose in 300 cc. quantities, because there are in these intestinal cases a distinct increase in the CO_2 combining power and a marked fall in the chlorides of the blood stream. As the chlorides fall, the CO_2 combining power rises and an alkalosis develops.

A lengthened clotting or bleeding time of the blood is supposedly due to some change in the blood calcium content and the effect of jaundice on this condition is misleading, in that a jaundiced person with a normal bleeding time may develop a tendency to hemorrhage which may be impossible to control at operation; on the other hand, one with an increased bleeding time may show no tendency to hemorrhage at operation. The duration of the jaundice and the age of the patient probably play important parts in this problem. The intravenous injection of calcium chloride has been used for a long time, as has also blood transfusion, whole blood and horse serum which may sometimes be most advisable.

The urinary tract is ofttimes not given the preliminary thought necessary to give pleasing results. The kidney function should be carefully estimated as previously mentioned and a pyelitis should always be treated and improved prior to surgical procedures unless an acute surgical con-

dition makes it necessary to accept these risks.

There are no more frequent affections, and ones that deserve accurate observation, than those of the cardiovascular system. The definite cardiac decompensation can be conservatively cared for by the surgeon. It is the apparently adequate circulatory system, in which a break may develop during the operation or several days after the operation which is of grave import.

The use of Lugol's solution in the toxic thyroid case and the use of insulin in diabetes have lowered the hazards of two previously disastrous metabolic disturbances which frequently complicated a surgical patient so suffering. There is, however, no method known to surely aid the patient who is 60 or more years old and this type of surgical patient should not be subjected to operative measures, particularly abdominal, without the presence of a definite clear indication for surgical intervention.

Surgical emergencies force the operator to accept the lack of preliminary investigation and adequate preoperative treatment and are, of course, in all cases, even the aged, always justifiable.

Lastly, the correct choice of anesthesia is essential. Opinions have been expressed that ether in the case of shock, hemorrhage or pulmonary disease is contraindicated and nitrous oxide oxygen-novocain analgesia is preferable. From a standpoint of immediate safety in strangulated hernia, general peritonitis, acute intestinal obstructions, and respiratory obstructions, local anesthesia is almost a necessity. From the late results, local or spinal anesthesia has no particular advantage over the two above-named methods and postoperative pneumonia develops more frequently after local than general anesthetic. Ether anesthesia contributing to greater relaxation, better exposure, decreased operating time, being always relatively safe, cannot but be a positive advantage. Even considering ether pneumonia (an erroneous idea), it is still the anesthetic of choice.

So now we come to the time when, sparing the patient every unnecessary distress and pain, and beginning when the last stitch is tied, the surgeon has assumed the postoperative care not only of the patient but the family as well, and ofttimes the latter process is far more difficult to handle than the former.

From the operating room to the bed the patient should be accompanied by the anesthetist or a trained assistant, either interne or nurse, because serious accidents can befall the unconscious patient and movement of the patient should be supervised.

The preparation of the ether bed is more or less routine and also the care until conscious is only a matter of intelligent observation and nursing.

For the first 18 hours, which is a critical period, the first essential is to combat the loss of fluid which has already taken place consequent to the operation and a further anticipated loss by vomiting. It is essential to instill, by Murphy drip into rectum, about 20 drops to the minute of glucose and coffee mixture, or any desired fluid medium best tolerated by the patient as directed by the surgeon, and to use normal salt solution by hypodermoclysis, about 5 cc. per minute as tolerated by the patient.

Pain should be controlled if possible by morphine gr. one-sixth or combined with 1:150 gr. of atropine if it is desired to neutralize the respiratory effect of the opiate. It is better that no narcotic at all be used than one of inadequate dose. If the discomfort can be controlled by milder acting drugs, codein or pantopon gr. ½ may be quite efficient. It is seldom necessary to use opiates longer than the second or third day and uncontrollable vomiting and possible influence on intestinal peristalsis are definite contraindications.

Modifications of anesthesia have reduced to a marked degree one of our most troublesome symptoms, nausea and vomiting. Where it exists, gastric lavage of warm water and soda may aid in its relief. I have used with marked success a small cotton pledget saturated with aromatic spirits of ammonia for inhalation.

Every surgical incision can be made more comfortable by placing the patient in the position which causes the least pull on the incision and sutures. This is purely a relief measure regarding which you can instruct the attendant when you first visit him after operation and one which will be thoroughly appreciated by both patient and nurse.

A troublesome symptom usually manifesting itself on the second day is abdominal distention and it is one that is extremely trying on the patient and may be regarded as some form of so-called adynamic or paralytic ileus of varying duration and intensity. Enemas and gastric lavage often give relief and surgical pituitrin may be indicated.

I have now used in about one hundred minor drainage cases cellophane which has been folded fan-wise in strips of varying lengths and thicknesses and boiled for drainage and have been favorably impressed with its remarkable drainage qualities.

It boils readily and handles nicely and while I have not up to the present time used it in abdominal drainage, its physical properties make it readily adaptable for all surgical drainage.

It appears to me to be superior to rubber tissue, split tubes and might be used folded fan-wise or as the wrapping for the cigarette (Penrose) drain with probably improved drainage.

Dressing the wound is quite important. Large dressings are not necessary unless drainage is expected and the wholesale use of adhesive tape to hold them in place is not advisable. In many instances pulmonary complications have been aided in their onset because this type of dressing interferes with abdominal respiration. The original dressing should be changed early and many times the first real comfort experienced by the patient is following its original removal. As we can hardly expect the first dressing to last for days, there should be frequent, possibly daily, changes.

Inability to void the contents of the urinary bladder may become an important phase of the patient's well-being. Usually the first eighteen hours are not accompanied by the ingestion of enough surplus fluid as to cause any discomfort of the bladder by distention. Encouragement, instillation of warm water into the rectum; heat over the bladder; the sound of running water; sweet spirits of nitre orally and, when permitted, the change of position or the propping of the patient in semi-upright position may eliminate the necessity for catheterization. If these methods do not get results, then the use of a catheter should be most careful, because the development of a cystitis in a patient whose surgical condition is not serious, by its use, is certainly indefensible.

In the uncomplicated case, by the third day the inner man begins to present himself in the form of hunger according to the old adage that: "We are just three days removed from a beast." It then becomes necessary to feed the patient, and I believe after two days of liquids it is safe to begin a soft diet.

Temperature, pulse and respiration rates having been duly charted during this time we may believe, if they are normal, that we have a clean wound and a respiratory apparatus free from infection, because the usual postoperative rise in temperature should subside by this time.

Castor oil or some suitable cathartic should be given and opinions differ as to the proper time to administer it as also does the type of operation that has been performed. But the fact that the majority of patients feel so much better physically and are so much clearer mentally after its use, leaves little doubt as to its value postoperatively.

Sleep is necessary and after withdrawal of the opiate, bromides luminal, veronal and others usually suffice to promote it along with acetylsalicylic acid or pyramidon to relieve the pain of mild nature if present.

Removal of the stitches may, in a majority of cases, be done on the 6th or 7th day, when it is my practice to paint the incision line and on each side for about 2 inches with mercurochrome and lay at about one inch intervals thin strips of adhesive tape with snugness across the incision before applying the sterile dressing.

The time when the patient is permitted to get up must be controlled by one's judgment and depends upon the type of operation and the type of patient operated upon. As one may readily see, in a less serious operation ambulatory treatment is desired while conservative rest in bed will aid and greatly facilitate the healing of a more extensive wound. This is also true in the case of the well nourished as against the poorly nourished, obese type which might require a more extended convalescence.

It has, because of the length of this paper, been impossible for me to include all of the care which should be used in the preoperative and postoperative treatment of the surgical patient, such as pertains to the special fields of the head, eyes, ears, throat, mouth, nose, and neck, the extremeties, the genitourinary, cardiovascular, pulmonary systems. The complications such as infection, hiccough, shock, hemorrhage, and psychosis have not been dealt with in this paper, but at a later date I hope to present this particular field, as it is one of vast importance to all those interested in surgery. In summary, allow me to repeat that preoperative and postoperative care is as essential to good surgery as is the ability to dextrously wield a scalpel. In closing, I feel it necessary here to acknowledge the help received from Dr. Walter Hughson who, with his reference, has prepared the chapter on this subject in the Practice of Surgery by Dean Lewis.

MALARIA CONTROL INVESTIGATIONS*

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U. S. Public Health Service and Director Malaria Control Investigations, Florida State Board of Health.

Notwithstanding the fact that Ross first infected "dapple-winged" mosquitoes with malaria and transmitted avian malaria with Culex mosquitoes in 1897-8; we are yet—32 years later—still wrestling with the problem of the control of malaria. To one not having responsibility for effecting control of the disease as a public health procedure, it would seem rather simple to control. We have no more definite knowledge concerning the agent of infection, the methods of diagnosis, the rationale of treatment and the prophylaxis of any communicable disease, than that which is held by us with regard to malaria. For centuries *paludismo*, or *malaria*, was associated with marshes and swamps. Our predecessors were on the right trail through the bogs and morasses, here and there striking a warm trail, such as "fog," "miasma," or "noxious effluvia," —nearly always associating malaria with water. Our literature on the subject of malaria dates to the century before Christ, while its existence probably has been as long as that of man or of mosquitoes. It was not, however, until the latter part of the 19th century that we had recorded direct suggestions of the mosquito connection with transmission. In the closing years of that century (1897-98), Ross and others proved the fact. Laveran had discovered and described the causative parasite just 18 to 20 years earlier in the latter part of the 19th century (1878-80).

Of decided historical interest in connection with early recognition of the devastating influence of malaria in this country and of active steps against it, is the record established by the City of Savannah, Georgia. In the year 1804 (128 years ago) an act "To Incorporate the Georgia Medical Society" was passed by the General Assembly of Georgia and was signed by the Governor, John Milledge, December 12, 1804, creating by law the Georgia Medical Society, "for the purpose of *lessening the fatality induced by climate and incidental causes*, and improving the science of medicine." Up to this time, rice was cultivated on the low grounds adjacent to the city—"up to the very door-sills of our homes." The first efforts of the Medical Society in its newly acquired corporate capacity and authority to adopt by-laws, were directed against rice culture, the Society holding that "there could be no worse or more malignant incidental cause of disease, than the *stagnant water which remains on a rice field exposed* to an ardent *summer's sun*." It was proposed to prohibit rice culture within a *radius of one mile of the city limits*. The rice lands and the rice crop were valuable, and the landowners could not be expected to contribute all to the health of the people. A plan was offered whereby a stipulated sum per acre was to be paid for the land and take a lien on it "that it never should be employed in wet culture." About the year 1817 the landowners came to terms and for $40.00 per acre agreed to bind their land "forever from wet culture." The city of Savannah at that time had a population of 4,000, of whom one-half were negroes. The city paid $200,000.00 into this project—a per capita tax of $100.00 for the taxpayers. (In these days of howling about "taxes" let us pause in admiration for the public spirit of another day.)

We all are more or less familiar with the history of major activities against malaria during the past 32 years. There are certain outstanding instances of control which we hold up as models. We mention Panama (where control measures continue to be applied and where the Gorgas Memorial Laboratory now studies malaria), our own brilliant records in protecting the armed forces under training in southern camps during the World War, the municipal malaria control demonstrations after the war in southern states. Recall the special studies on the relation of impounded waters to the incidence of malaria and to the resultant regulations and malaria control about the hydro-electric developments. Think of the attempts to control the disease by quininization in Italy, in certain counties in Mississippi, and in other localities. Consider the evanescent buoyancy lent by the enthusiastic but misguided administrators in attempting Anopheles control by letting "gambusia" or top-feeding minnows do the work. Again let us mention that bats have gotten into pseudo public health and newspaper "belfries" and repeatedly have been offered as a panacea for all our mosquito worries. Individuals and corporations have been duped into wasting money in building so-called batteries, while scientists explored bat caves and found them favorite resting places for mosquitoes. Bats

*Read before the 4th Annual Meeting of the Florida East Coast Medical Association, Jacksonville, Oct. 28, 29, 1932.

were found to eat moths, but *not mosquitoes.* The propagation of the dragon-fly (odonata) for use as mosquito hawks has rather seriously been recommended; the "animal screen," to attract mosquitoes to lower animals and away from man, has been suggested; encouragement of production of predaceous, aquatic bugs, beetles, and the like, to destroy mosquito larvae, has had its fling. On the other side of biological control, various types of vegetation have been suggested to repel imagoes, or to destroy the aquatic forms. Of the latter, one of the earliest was the planting of Eucalyptus trees to dry up swamps; the growing of castor bean and more recently the growing of clover and legumes to discourage Anopheles or render them non-infective.

In curative and prophylactic medicine, we have had no dearth of proposed remedies. On account of the widespread and generally non-fatal attacks, quackery and nostrums have blossomed forth. Some of the public press has advertisingly besmirched its columns and banked its cash, while pretending a more or less Simon pure editorial attitude. The swampy roadside and countryside are plastered with the three-day "chill tonic" signs to encourage self-diagnosis and self-treatment.

Those who are earnestly and scientifically trying to control malaria too often are groping in the dark as to where cases are, in order that they be properly treated, medicinally and in a public health way. *Every case of malaria should be considered serious enough to be examined, reported and treated by a practising physician.* And I may add here that at least one thick blood specimen should be examined for parasites, by one trained in this procedure.

Briefly, our present day program for the control of malaria contemplates:

1. *Information as to Where Malaria is.* We all know in a general way, that malaria is most prevalent in rural sections, that in the development of cities much drainage is accomplished and a larger percentage of people is protected by screened houses. Unfortunately it is probable that a large majority of rural cases of malaria are never seen by a physician. Home remedies and nostrums are employed. The physician may be called upon to sign the death certificate. So, morbidity reports are, and will continue to be, lacking. In order to promote malaria control in the counties suffering greatly from malaria incidence, it becomes necessary to conduct some form of investigation among the population. Reports of deaths are sufficiently complete in Florida for dependable information on malaria, were causes of deaths always given correctly. Also, in this connection, account must be taken of the prevailing type of infection, if one is to estimate morbidity from the mortality rates, for death rates would be expected to be higher where malignant tertian (*p. falciparum*) prevailed, than where benign tertian (*p. vivax*) was the offender. So, in this respect the death rates may not indicate the true prevalence of malaria. Histories of malaria obtained from the people are not reliable. The spleen index of school children has its advantages and disadvantages. In Florida we are now making a survey of all of the schools in several counties showing high mortality rates from malaria. It is believed that the examination of thick blood smears from the school children will furnish the best obtainable index of prevalence and at the same time give us a desired control on the reported death rate. In addition we are making a census, if you please, of the Anopheles in and near homes in these counties, preparing spot maps on both the blood index and the Anopheles density.

2. *Treatment of Cases.* As previously stated, all cases of malaria *should be treated by the physician.* If it were possible to bring this about, malaria control would be simplified. In our work all found positive on blood examination are urged to be treated by the family physician. The advice is taken better than the medicine, of course.

3. *Control of the Activities of the Responsible Vector:* This is the most important phase of the whole subject with respect to future malaria control. Control contemplates:

(a) Prevention of Anopheles production.

(b) Limiting activities of the imagoes, or adult Anopheles. Under (a) destruction of the production areas is the ideal. This is done by drainage or by filling, which is but a form of drainage. General control of rural malaria by this method, unless done on a slowly progressive scale, would be an economic unfeasibility. When the time comes that our average county has 100,000 instead of 25,000 population, or less, and there is demand for good land and the poor land reverts to uninhabited forest, then drainage and occupancy of agricultural lands will be feasible.

Other methods of preventing production are those wherein the bodies of quiet waters are so treated as to prevent, or limit, the emergence of Anopheles. These include clearing areas where

water is to be impounded, cleaning of lakes, ponds and pools of brush, vegetation, drift and flotage; oiling or the application of other larvicides, such as Paris green.

(b) Limiting of activities of adult Anopheles: This is covered by one word—"Housing." The "big house" and the cabin in the old days were more or less sealed up at night to keep out the "night air" and "chills." Then came smudges, bed-nets and the sliding removable screen. Now we have found that any kind of a "shack" can be screened at a cost of about $7.00. I have a feeling, almost to the degree of a conviction, that the permanent thing necessary in rural malaria control in this country, is a re-adjustment in rural housing. How much individual public health attention can be given to the rural family, with population scattered, living in out-of-the-way places and in "ramshackle" huts? In the average southern county, most of the rural folks are negroes. They like to congregate; they do congregate at night. They are just as strong for community life as ants or termites. They can never have adequate health protection until they are brought together in rural villages. Every modern city has its building code. Certain specified requirements must be met. But one who establishes a home in the country generally assumes that nothing but health can enter. It is erroneous to think that the country dweller, in the South, especially, is surrounded by more healthful conditions than the resident of the city. Modern environmental sanitation and hygiene must, however, be extended to the rural population.

AVULSION OF THE PHRENIC NERVE*

Report of a Case.

Claude Anderson, M.D.,
Tampa.

L. F. P., white male. Barber, age 38.

Chief complaint: Hiccough of four years' duration.

History: Onset was four years ago without apparent cause. The first attack lasted eight days but since then the patient has had many attacks of variable duration; some lasting only a few hours but others persisting for several months. They have tended to become more severe and more frequent in occurrence. His most recent attack lasted forty-five days, ceasing only a few days before I saw him. Every form of medicinal treatment including sodium amytal intravenously, avertin and spinal anesthesia had been tried at various hospitals in an effort to effect a cure but had resulted in only temporary relief. The patient stated that in July, 1931, the right phrenic nerve was sectioned with only temporary relief of symptoms. A few months later, the left phrenic nerve was exposed and frozen with ethyl chloride which also gave temporary relief. Later the symptoms recurred and an attempt was made to avulse this nerve but was unsuccessful. Since this latter operation, he had developed a loss of power in the left hand and inability to completely raise the arm above the head.

Beginning in 1922 and extending over a period of four years, the patient had been subjected to nine abdominal operations which included an appendectomy, two operations for peritonitis, a cholecystostomy, cholecystectomy, removal of sponge, excision of duodenal ulcer and gastro-enterostomy. He stated that one of our most eminent surgeons told him that his hiccoughs were due to adhesions and he was advised to have an abdominal operation for them.

Since July, 1931, his weight had decreased from 186 to 138 pounds. Frequent attacks of hiccough had so interfered with his work and nutrition that he was quite desperate and he threatened to commit suicide unless something was done for him. He was advised to go into the hospital to be studied to determine, if possible, the etiological factor involved but this he refused to do.

It was my good fortune to see him in one of these attacks a few days after his first consultation. At this time he was hiccoughing 180 times a minute, there was slight cyanosis and much difficulty in breathing. After the attack had subsided to some extent we examined him under the fluoroscope and found spasmodic contractions of both sides of the diaphragm; neither leaf was paralyzed.

On October 6, 1931, both phrenic nerves were injected with 2 c.c. of 2% novocaine without any relief. A few days later he was sent into the hospital and under local anesthesia the left phrenic nerve was exposed, injected with novocaine, severed and completely avulsed. During the avulsion the patient complained of a great deal of pain in the anterior mediastinum and precordial area but he refused nitrous oxide. We were permitted to continue the operation only

*Presented before the staff of the Tampa Municipal Hospital, July 14, 1932.

after a great deal of persuasion. About fourteen inches of the nerve was removed, or all of it distal to the point where it was severed. A few minutes after the operation was concluded the patient was permitted to leave the hospital. Since then he has been entirely free from attacks.

Originally, it was thought that he would probably have to have the right phrenic nerve avulsed but thus far this has been unnecessary. He was fluoroscoped a few days after operation and the left side of the diaphragm was about two inches lower than the right. This lowered position undoubtedly was due to adhesions to the diaphragm preventing it from rising as it usually does after the phrenic nerves have been paralyzed.

Temporary or permanent paralysis of one or both leaves of the diaphragm has gained a permanent place as a valuable therapeutic measure in certain thoracic lesions and as a palliative and curative measure in certain cases of singulitis. It is now recognized as a useful procedure in our best tuberculous clinics and is used in an increasing number of cases in which compression and rest of the lung are indicated. In persistent cases of singulitis, which do not respond to other methods of treatment, it is an invaluable procedure and will practically always result in a symptomatic cure. Permanent paralysis of the diaphragm seems to have little or no effect on the well-being and health of the patient and usually he is able to carry on the duties of life without hindrance.

In plastic operations on the diaphragm, as for diaphragmatic hernia, tumors of the diaphragm either on the thoracic or abdominal side, liver abscess, and in some cases of sub-diaphragmatic abscess it is a most useful procedure preliminary to operation. In diaphragmatic hernia it often gives symptomatic relief if operative repair cannot at once be undertaken.

The etiology in this case is obscure. There were no gastro-intestinal symptoms that would suggest disease of the stomach or duodenum. It apparently was not related to dietary indiscretions. There was no history of encephalitis and it is improbable that it was a case of epidemic singulitis. It seems plausible that in this case the symptom of hiccough could be attributed to adhesions between the upper abdominal organs and the diaphragm, especially since the diaphragm was found to be definitely lowered after operation.

THE FUNCTION OF THE NEWLY FORMED AMERICAN ACADEMY OF PEDIATRICS*

WM. MCKIBBEN, M.D., F.A.A.P.,
Miami.

Six million, or one-third of the children of the United States, are more than seven per cent underweight for height. In our examinations of recruits for the Great War, in a manufacturing city of a quarter of a million people, we found an even worse situation. I recall that every one of our first nineteen applicants were rejected. This physical unfitness could have been prevented in childhood by the adoption of a simple health program insuring normal, healthy growth by correcting physical defects, home control, overfatigue, improper diet and faulty food and health habits.[1]

The baby, carefully supervised with periodic check-ups during its first year, and a nutritional triumph at eighteen months, is the potentially undernourished child of three to six years of age, whom we find then, seven, ten or more per cent underweight. This means one thing—scant regular medical supervision and attention in the intervening period.[2]

Careful diet is increasingly trespassed upon, scales and regular schedule of rest eliminated, the child's personal dislikes asserted, discipline becomes lax at the table; to avoid starvation, indiscriminate feeding of sweets is resorted to between meals with killing of the appetite for the next meal, and thus a vicious circle is established. Social maladjustments result in an abnormal emotional outflow with a secondary physiological effect on digestion and nutrition. Cannon, of Harvard, has shown that under emotional strain, there is increased motor activity, quickened metabolism with increased destruction of glucose; digestion and absorption come to a standstill. The parasympathetic and sympathetic nerves are reciprocal. This illustrates the obvious need of happy contacts at home and with playmates, the avoidance of overfatigue with resulting anorexia, insomnia, and irritability.[3]

Malnutrition, naso-pharyngeal obstruction with its many sequelae, postural defects, eye strain, teeth defects, poor hygiene, the exanthemata with too short a convalescent period allowed, all these follow this sad neglect of the pre-school age.

*Read at monthly Staff Meeting, Victoria Hospital, Miami, August 26, 1932.

It was to combat this condition, and to establish and maintain the highest possible standards for pediatric education in medical schools, hospitals, pediatric practice and research, to perpetuate the history and best traditions of pediatric practice and ethics, and to maintain the dignity and efficiency of pediatric practice in its relationship to public welfare, that the American Academy of Pediatrics was formed, the idea being entirely humanitarian or altruistic rather than for pecuniary profit.

When President Hoover started the great plan for the improvement of the welfare and health of our country's children, which resulted in the White House Conference, it was found that there was no organized body of pediatricians to carry on, authoritatively, this movement. The Section on Pediatrics of the American Medical Association and the American Pediatric Society have a very limited and scientific scope, and have never actively engaged in public health matters. Consequently, there was need of an organized body of every thoroughly qualified pediatrician in the United States to foster and to stimulate interest in pediatrics and correlate all aspects of the work for the welfare of children which properly come within the scope of pediatrics.[4]

The child-welfare minded American public insists on the preservation, protection and guidance of children; lay organizations and public health workers have heretofore been active without guidance of cooperation from pediatricians.

To see that the Academy becomes actively engaged, and to avoid the perils of state medicine, committees from all sections of the United States have been appointed: Medical Education, Hospitals and Dispensaries; Relation to White House Conference; Relation to Philanthropic Agencies, Welfare Workers and Public Health Authorities; School Health and Hygiene; and Mental Hygiene.

The Academy divides the United States into five regions, in charge of regional committees: East, South, Midwest, West and Canada; to better deal with local problems, and to hold regional clinical meetings.

The regional committees, in turn, select state committees to interest themselves in all pediatric problems, and to cooperate with all child welfare and child health agencies.

Thus will be benefited, the children of the country, pediatric education, and last, the pediatricians themselves who will occupy the sphere to which they belong, that of taking their places in child welfare matters and in preventive pediatrics.

To be eligible as a Fellow of the American Academy of Pediatrics, a candidate must have a minimum of five years in pediatrics; evidence of fundamental training; productivity in one or more of the following: teaching, investigative work, clinical studies, publications and public activities relating to pediatrics; clinical experience and standing as determined by Fellows in his region. Governmental activities related to pediatrics shall be considered as proper qualification for fellowship.

To obtain admission as a F. A. A. P., a physician must be proposed by two members of the Academy in his region who are not officers. His application is then sent to the regional committee which sends a letter to every member of the Academy in that region, asking their opinion. The regional committee then decides whether the applicant is eligible and, finally, he must pass the examination of the executive board. A recent modification to the requisites was made last winter: that a pediatrician who lived in a small place, so little in fact that he could not be expected to make his living entirely out of pediatrics, would be accepted.[5]

Dr. Lawrence T. Royster, Professor of Pediatrics and head of the department, University of Virginia, director of the American Child Health Association, has just resigned as regional head on account of ill health, and Dr. E. Clay Mitchell of Memphis, is regional head in the South.

Improvements in sanitation, water, milk, food and communicable diseases have in the past been due to community or group enterprises. But now there is a tendency to individualization, and the personal physician is recognized as being in the most strategic position for supervising the health of normal children.

In conclusion, it is well to emphasize again the fact that thorough and systematic health supervision is not offered by the physicians of our State to the children whom they consider members of their medical practice, but they resist rather than encourage the growing popular demand for such service. Anyone doubting this assertion is referred to the recent publication of the White House Conference entitled, "Health Protection for the Pre-school Child."[5]

This Conference has aroused much interest in

preventive pediatrics; the medical profession should offer service and leadership in the whole child health movement and the Florida State Committee of the American Academy of Pediatrics, with Dr. Thomas Buckman, of Jacksonville, as its state chairman, is anxious to cooperate to accomplish practical results.

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SHOULD A PHYSICIAN TREAT MOUTH INFECTIONS?

J. Harold Klock, A.B., D.D.S.,
Miami.

In writing upon such a delicate subject it will be the writer's object to state in a conservative and understandable manner the part, in his opinion, that the medical and dental professions should play in the treatment of mouth infections.

This is a hard task since in the past much of the antagonism and lack of coordination between the two professions has arisen akin to this discussion.

The physician (especially the general practitioner) being entrusted with the health of his patient, must treat or advise treatment of the various maladies that may arise in any part of the body. Likewise, when a patient presents himself to his physician with an inflamed mouth, he naturally and rightfully feels that it is his privilege to treat this inflammatory process. Many physicians, after recognizing the condition, immediately refer the patient to a dentist, while probably the larger number initiate treatment themselves.

If mouth infections were similar to inflammatory processes elsewhere in the body, the physician would be as well qualified to treat the condition as a dentist, but such is not the case. The predisposing conditions, while in some cases constitutional, are predominantly of a dental nature. The treatment, therefore, to be efficacious, must not be merely with antiseptics but must comprise correct diagnosis, instrumentation, and removal of the predisposing causes such as faulty dentistry, partially erupted teeth, traumatic factors and so called "pockets" which are nearly always in evidence adjacent to the teeth.

WHAT IS THE DUTY OF THE PHYSICIAN?

When a physician attends a patient with a mouth infection, he may or may not wish to diagnose and treat the case. Considering the importance of the predisposing factors as above mentioned, many physicians prefer to turn the case over immediately to a competent dentist, or to at least seek dental consultation.

Another method of approach which would undoubtedly find favor with most dentists, would be for the physician to reduce the acute condition by treatment, and then refer the patient to a competent dentist for treatment of the chronic condition, which invariably remains. This would involve, primarily, the analysis and elimination of the predisposing factors. If this is not done, especially following the acute exacerbation of Vincent's infection, there is a slow liquifaction of the alveolar bone adjacent to the teeth, which not only becomes a focus of infection but, in time, may cause the loosening and ultimate loss of the teeth. This liquifaction of bone is undoubtedly due to the allergical shock of the bacterial toxins.

The dangerous aspect of these infections is that, except in the acute stage, there is no pain noticeable to the patient. Mouth comfort is therefore no criterion by which the success or failure of treatment may be judged.

IS VINCENT'S INFECTION CONTAGIOUS?[1]

The idea that Vincent's infection is contracted by kissing or from drinking cups seems very questionable. Reppeto[2] and others agree that in the normal mouth both the Vincent's spirochete and fusiform bacilli can be demonstrated in some quantity. Vincent[3] in 1899 found fusiform bacilli in 78% of all normal mouths. Pratt[3] found the Vincent organisms present in small numbers in throats of 100% of subjects examined. H. Steuer found the miller Vincent organisms in the vast majority of grade A mouths. Other authorities state that although these organisms can be demonstrated, it is by kissing or direct contact that a more virulent strain of organisms is introduced, and likewise the resulting infection.

Experimenters[4] in one of our leading universities have endeavored to infect what they considered healthy mouths with specimens taken from active cases of Vincent's infection. In every

case, their efforts to transmit the disease in this method met with failure; which tends to refute the orthodox contagion theory, and substantiate the importance of local and constitutional predisposing factors.

The opinion is therefore advanced that the mouth has a normal bacterial flora composed of Vincent's spirochetes, fusiform bacilli, streptococci, and many other organisms. If conditions in the mouth predispose to an increase in the organisms to abnormal proportions, disease, to varying degrees, results.

The main and chief consideration in the treatment of Vincent's infection is therefore the "soil" or the predisposing causes. If medication by local and intravenous methods is used, temporary relief will be noted; however, recurrence, if only in a chronic form, is inevitable. To prevent recurrence, pocket elimination by conservative or radical surgery is often indicated. The prognosis is usually favorable if osseous liquifaction has not destroyed one-half or more of the supporting alveolus.

WHAT IS THE CONSTITUTIONAL SIDE OF VINCENT'S INFECTION?

It is unquestionably true that many conditions diagnosed as Vincent's infection are merely secondary to a predisposing condition of a constitutional nature. It is the writer's opinion that many cases of acute Vincent's infection are in reality a form of malnutrition or possibly hypovitaminosis closely akin to scurvy. This is the type of case that requires medical consultation and treatment. The dentist who fails to recognize the medical aspect of the case, or to refer the patient for this medical treatment, does his patient the same injustice as the physician who treats the case alone.

The answer to the problem undoubtedly lies in the necessity for the two professions to cooperate and exchange ideas, which will tend to create mutual good will and respect for each field of practice.

FOOT NOTES

1. Used as an example to illustrate the influence of predisposing factors to an increase of the normal mouth bacteria.

2. W. M. Reppeto: Journal American Dental Association. August, 1931, page 1410.

3. Joseph Eller and Charles Rein: Journal A. D. A., Dec. 31, page 2353.

4. This information has come direct to the writer from the Dean of the school in which these experiments were conducted. For obvious reasons the request was made not to disclose the identity of the institution or experimenters.

LAST CALL

The Committee on Scientific Work urgently requests all members who wish places on the program at the annual meeting in Hollywood to make application at once. This is the last call as the Committee will meet in January to select the papers which will comprise the scientific program. A 50-word synopsis should accompany each application.

Applications should be mailed to Dr. L. M. Anderson, chairman of the Committee, Box 81, Jacksonville.

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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TWENTY-FIRST DISTRICT—H. D. CLARK, M.D. . . *Ft. Pierce*
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MALARIA AND PARESIS

The therapy of paresis by means of an induced and controlled attack of malaria is now widely recognized as a procedure of considerable benefit. As originally introduced, and as yet most widely practiced the malaria inoculation is artificially effected by the transfer of blood from either an autochthonous case of malaria or a case of paresis experiencing this form of therapy. Another method of inoculation is effected by the application of infected mosquitoes, thus inducing the disease in a natural manner. The scarcity of persons trained in malaria parasitology, together

with the technical difficulties to be surmounted, are probably responsible for the very slight degree to which this latter practice has been utilized. Yet in this manner several of the most serious objections to the inoculation by means of blood are avoided.

The Florida State Hospital is one of the few institutions for the care of the insane where malaria inoculations are effected by means of infected mosquitoes. This facility is available through the collaboration of the Station for Malaria Research, located in Tallahassee. The experience so far gained in this institution indicates that, owing to a matter of racial tolerance, the employment of benign tertian malaria is practically only available to white patients. Furthermore, while admittedly a heroic form of therapy, yet if care is taken to select patients in good physical condition, the malaria infection may be permitted to undergo its evolution with very little risk to the patient. Benign tertian strains differ considerably in their virulence, and the station is fortunate in possessing a strain that is really benign and is readily controlled, if indicated, by the judicious use of quinine.

Malaria therapy, induced in a natural manner, is now available under certain circumstances to the physicians of Florida in the treatment of private patients. Needless to say, such patients should be hospitalized in screened wards while experiencing malaria therapy, and, on the termination of the malaria attack, be effectively treated so that on their release they will not become carriers for the dissemination of malaria.

The Station for Malaria Research will receive on appointment and inoculate without charge, private patients of practicing physicians of Florida who make application to Dr. Henry Hanson, State Health Officer, Jacksonville, and can satisfy the State Health Officer, that all precautions which should surround this mode of therapy will be observed. Applications for appointments must be transmitted to the station through the State Health Officer in order to receive consideration.

Patients must go to Tallahassee at their own expense. The inoculation and verification of the infectiousness of the mosquitoes employed will require barely half an hour. The director of the station requires that he be informed of the onset of the malaria attack, and will advise the attending physician of the proper care of the patient during the evolution of the malaria infection.

CHARITABLE CONTRIBUTIONS

Civic welfare organizations might well give more thought to the contributions made by medical men to charity. As a group, physicians are without doubt the greatest givers to the poor. In reading the list of contributors to a certain municipal community chest drive recently, the names of those persons giving considerable amounts of money were most conspicuous. The medical men in the same community are donating in services thousands of dollars worth of their time to this same charitable organization. This is not something that it is easy to compute in terms of dollars and cents, but for the public's benefit it might be well to estimate it thusly, so that at least some idea may be given the layman of organized medicine's contribution to the community in monetary terms. In communities of 100,000 to 200,000 population where the welfare organizations estimate their needed funds for one year at, say $100,000 to $200,000, if one were to examine the records of the charitable hospitals, one would find a small group of medical men, say 100 or probably less, actually giving several times this amount in services. In addition to this, many of these men contribute financially to charitable enterprises. Business men who spend two or three days soliciting funds for such enterprises and contribute one to two hundred dollars annually are to be commended in the highest terms for their altruistic spirit. However, they should not be unmindful of the fact that the medical man's contribution to the same project is far greater in most instances.

In many communities, in addition to voluntary cash contributions, taxes are levied for such work. The public too often is uninformed as to the manner in which such funds are spent, laboring under the impression that the medical men serving charitable projects are renumerated therefor, when, as a matter of fact, they are the only regular workers who do not profit financially thereby.

Full-time welfare workers in many instances are trained theoretically and practically for their vocation, many of them spending years in our larger universities. It might be well for institutions giving such instruction to devote more time to teaching these workers the altruistic phase of the doctors' part in carrying on charitable medical work. This is mentioned because of the tendency to what seems to border on exploitation of the medical profession by such workers. Carrying out definite programs of statistical attainments without regard for the financial status of the patient too often results in the medical man gratuitously rendering service to those who should be paying some fee. This deprives him of income and spends funds intended for real charity.

PRESIDENT'S ADVISORY COMMITTEE

Some years ago, among the special committees appointed by our president was one entitled the "President's Advisory Committee."

In the last few years no such committee has been appointed. Recently, however, it has seemed best to re-organize it. Not infrequently, most important questions concerning the policy and methods of our association arise which require careful, constructive thought before any action is taken. The solution of such problems will certainly be greatly helped by the advice of this committee. The committee will be composed of the five immediate past presidents: Drs. G. H. Edwards, Orlando; Julius C. Davis, Quincy; Henry C. Dozier, Ocala; Frederick J. Waas, Jacksonville, and John A. Simmons, Arcadia.

STATE NEWS ITEMS

Dr. Gerry R. Holden, president of the State Association, and Dr. Stewart Thompson, business manager, visited Ft. Myers and Tampa during the early part of November in connection with some of the Association affairs.

* * *

Dr. and Mrs. S. B. Forbes of Tampa are at present in Vienna, Austria, where Dr. Forbes is attending clinics and lectures on eye, ear, nose, and throat work. They will return in February.

* * *

Dr. L. B. Bouchelle and son, Anderson, of Daytona Beach, recently motored to Sanford.

* * *

Dr. A. R. Beyer of Tampa went to New York in October as a guest of Dr. Fred H. Albee. Dr. Beyer took a course in bone surgery at Columbia School and Hospital.

* * *

Dr. and Mrs. C. B. Wilson of Sarasota have returned from a two weeks' trip to Washington and New York City. In Washington Dr. Wilson attended the session of the Seaboard Airline Surgeons and in New York he took medical postgraduate work.

* * *

THE COLUMBIA COUNTY MEDICAL SOCIETY SETS THE PACE FOR 1933. A ROSTER OF ITS MEMBERS ACCOMPANIED BY A CHECK TO COVER 100% OF DUES FOR 1933 WAS RECEIVED JUST AS THIS JOURNAL WAS GOING TO PRESS. WE CONGRATULATE THIS VERY ALERT SOCIETY.

The following members of the Association attended the twenty-sixth annual meeting of the Southern Medical Association, held in Birmingham, November 15th to 18th:

Andrews, C. A. Tampa
Baltzell, N. A. Marianna
Blake, Wm. C. Tampa
Burch, R. N. Miami
Cason, T. Z. Jacksonville
Claxton, W. A. Jacksonville
Cook, George L. Tampa
Coplan, Milton M. Miami
Dickinson, J. C. Tampa
Dunaway, C. E. Miami
Estes, Jas. L. Tampa
Fort, F. L. Jacksonville
Freeman, Mary Perrine
Gachet, N. L. Century
Gammon, Julian E. Jacksonville
Grimes, D. H. South Miami
Haggard, Wm. A. Miami
Hanson, Henry Jacksonville
Hardy, Geo. E. W. Tampa
Harkness, R. B. Lake City
Henderson, R. P. Tampa
Hodsdon, B. F. Miami
Holloway, Luther W. Jacksonville
Ira, Gordon H. Jacksonville
Jelks, Edward Jacksonville
Jobson, A. M. C. Tampa
Kendrick, O. G. Tallahassee
Kirby-Smith, J. L. Jacksonville
Milton, J. D. Miami
Mols, Edith P. Tallahassee
Moor, F. C. Tallahassee
Morton, Rosalie S. Winter Park
McRae, E. H. Tampa
Norris, S. R. Jacksonville
Orr, Louis Orlando
Osincup, Gilbert S. Orlando
Payne, W. C. Pensacola
Peek, Eugene G. Ocala
Quina, M. E. Pensacola
Royce, Clayton E. Jacksonville
Smith, D. T. Gainesville
Taylor, H. Marshall Jacksonville
Thames, Rufus Milton
Thomas, E. C. Miami
Turberville, J. S. Century
Vogt, F. A. Miami
Webb, Carol C. Pensacola
Wilhoit, Sterling E. Quincy

* * *

Dr. and Mrs. B. R. Tinkler of Lake Wales attended the rodeo held in Arcadia on November 11th.

* * *

Dr. E. W. Warren, Palatka, Dr. C. B. Wilson, Sarasota, and Dr. Stewart Thompson, Jacksonville, were subpenaed as witnesses in the Federal Court case of T. C. Whitehurst in Tampa Tuesday, November 29th, and were not released until Friday noon, December 2nd. The charge against T. C. Whitehurst was for using the mails to defraud in connection with making application to the State Board of Health for a Certificate of Registration. It was claimed that no license had ever been issued to T. C. Whitehurst by the State Board of Medical Examiners. Whitehurst plead guilty.

Dr. S. A. Scuderi of Tampa recently spent several weeks in California and other western points.

* * *

Dr. James B. Parramore of Jacksonville spent two weeks in October in New York City where he attended clinics in the New York Eye and Ear Hospital and the Post-Graduate Hospital.

* * *

Dr. G. H. Edwards of Orlando was recently made a member of the Advisory Public Relations Committee, a sub-committee of the Committee for the Study of Cost of Medical Care.

* * *

Dr. J. N. McLane of Pensacola recently received a Fellowship in the American College of Surgeons.

* * *

Dr. and Mrs. E. S. Gilmer and Dr. and Mrs. W. M. Rowlett were among those who attended Homecoming at Gainesville recently.

* * *

Dr. and Mrs. Reddin Britt of St. Augustine and Dr. and Mrs. J. P. Tomlinson of Lake Wales were guests of Dr. and Mrs. John E. Maines, Gainesville, during Homecoming.

* * *

Dr. Ralph N. Greene of Jacksonville was the principal speaker at the local Exchange Club recently. Dr. Greene spoke on the importance of rest and relaxation to mental as well as physical health.

* * *

Dr. Gerry R. Holden was the principal speaker at the annual meeting of the State Dental Association held in Hollywood, November 4th. Dr. Stewart Thompson, business manager, was also present, checking with the Hollywood Beach Hotel manager arrangements for the annual meeting of the Florida Medical Association next May. Drs. Holden and Thompson met with the Broward County Medical Society on the previous evening, going over preliminary plans of the entertaining society.

* * *

Dr. Leland Carlton was in charge of the program of the Tampa Kiwanis Luncheon, November 30th. The entire membership entered into the fun brought out in the program and the applause following each number was indicative of the enjoyment of those present. Dr. H. Mason Smith and Dr. Stewart Thompson attended the luncheon as Dr. Carlton's guests. Dr. Smith was asked to speak to the group with reference to the formation of a John S. Helms Memorial Association.

At the twenty-sixth annual meeting of the Southern Medical Association, held in Birmingham, November 15th to 18th, the following officers were elected for 1933:

President—Irvin Abell, Louisville, Ky.

First Vice-President—James R. Garber, Birmingham, Ala.

Second Vice-President—Hugh J. Morgan, Nashville, Tenn.

Chairman of Council—Homer Dupuy, New Orleans, La.

Chairman of Board of Trustees—J. Shelton Horsley, Richmond, Va.

The next session of the Association will be held at Richmond, Virginia, in November, 1933.

* * *

Dr. J. S. McEwan of Orlando recently spent an extended vacation in New York City, where he visited surgical clinics.

* * *

Dr. R. O. Cooley of West Palm Beach has returned from a vacation spent in Weaverville, N. C.

* * *

Dr. J. H. Blackmon of Tampa visited Dr. A. A. Poucher of Wauchula recently.

* * *

Dr. Jack Halton of Sarasota recently received the community service medal presented by the Sarasota Bay Post No. 30, American Legion, in recognition of his work in the Legion's underprivileged child clinic.

* * *

Dr. G. C. Tillman of Gainesville received the degree of Fellow of the American College of Surgeons recently.

* * *

Dr. D. W. McMillan, Pensacola, who is heading the Family Welfare Agency's drive for funds, recently made a series of three talks over WCOA about his African game hunts, as a means of obtaining publicity for the campaign.

* * *

Dr. Henry E. Palmer was host at his home in Tallahassee recently to the Tallahassee Kiwanis Club.

* * *

Dr. and Mrs. John Williams and Dr. B. M. Rhodes of Tallahassee attended the football game in Montgomery, Ala., on November 12th.

* * *

Dr. and Mrs. P. L. Dodge of Miami have returned from an extended vacation spent in New York and the New England states where they visited friends.

Dr. J. W. Hood of Ocala has added to his collection of relics and antiques several interesting items, including a watch over 200 years old that winds with a key, and a druggist's mortar over a century old which was formerly used to pound up herbs.

* * *

Dr. and Mrs. John R. Pearson of Miami have returned from Indianapolis where Dr. Pearson attended the International Medical Assembly.

* * *

Dr. M. J. Myres recently spent some time in Washington, D. C.

* * *

Dr. A. H. Freeman of Ocala recently addressed the Ocala Rotary Club on "Some Economics of Medicine."

* * *

Dr. H. H. Fox of Miami was chosen chief of staff at the annual election meeting of the Riverside Hospital recently. Dr. J. M. J. Luke was selected assistant chief. Dr. Robert T. Spicer was named staff secretary; Dr. Kenneth Phillips, medical chief; Dr. S. E. Chambers, surgical chief; and Dr. Homer L. Pearson, chief of obstetrics and gynecology.

* * *

Dr. E. M. Hendricks was the principal speaker at the Ft. Lauderdale Kiwanis Club recently. Dr. Hendricks gave a report on the tri-county mosquito project on which the Broward County Medical Society is working.

* * *

THE ORANGE COUNTY MEDICAL SOCIETY REPORTS 100% OF ITS MEMBERSHIP DUES PAID FOR 1932. THIS IS A SPLENDID ACHIEVEMENT FOR THE SOCIETY WHICH IS CLOSING A YEAR OF UNUSUAL ACTIVITY ALONG MANY LINES.

* * *

The Florida State Board of Medical Examiners met in Jacksonville on November 15th and 16th to examine 33 applicants for licenses to practice medicine in Florida.

* * *

Dr. William R. Warren of Key West was the principal speaker at a recent meeting of the P-T-A of the Division Street School.

* * *

Dr. S. A. Clark of Lakeland was elected president of the Midland Medical Society at its annual meeting held in Tampa the latter part of October. Other officers elected were: Drs. J. T. Jackson, Dade City, first vice-president; Geo. W. Hardy, Tampa, second vice-president, and Robert C. Black, Tampa, secretary and treasurer.

DR. T. H. HUDGENS

Dr. T. H. Hudgens, Sneads, died following an illness of only a few hours, on August 28th.

Dr. Hudgens was reared at Pinkard, Ala. Following his graduation from the Medical Department of the University of Alabama in 1910, he settled at Sneads where he became an outstanding citizen and community servant. He was active in civic and church affairs; was surgeon for the L. & N. railway and local health officer. Dr. Hudgens' untimely death was a great shock to his many friends in western Florida, Alabama and Georgia.

Dr. Gerry R. Holden, president of the Association, and Dr. Henry Hanson, State Health Officer, were guest speakers at the Palm Beach County Medical Society meeting, November 28th.

* * *

Dr. and Mrs. L. M. Anderson, Lake City, were visitors in Jacksonville the early part of December.

* * *

Dr. and Mrs. H. E. Merryday of Daytona Beach spent Thanksgiving day with relatives at Palatka Heights.

* * *

At the meeting of the Hillsborough County Medical Society held in November a committee composed of Dr. H. Mason Smith, Dr. Bundy Allen and Dr. J. W. Taylor was appointed to encourage, assist and sponsor a movement for a memorial to Dr. John S. Helms.

This committee has held several meetings and a movement has been definitely started toward the formation of a John S. Helms Memorial Association which will be organized early in January. There are plans made by the Committee together with the friends of Dr. Helms to work toward a big objective. While the type of the memorial has not been decided the one most favorably considered by a large number of people is a portrait of Dr. Helms in bronze or marble on a large pedestal to be set in Marjorie Park near the Tampa Municipal Hospital.

* * *

Dr. Edward Jelks of Jacksonville was elected president of the Florida East Coast Medical Association at its annual meeting held in Jacksonville in October. Dr. E. C. Swift, Jacksonville, was elected first vice-president; Dr. H. M. Walker, Miami, second vice-president, and Dr. Homer Pearson, Miami, secretary-treasurer. The next session of the organization will be held in Miami.

Dr. H. E. Miller of New Smyrna recently spent a week in Savannah.

* * *

Dr. L. W. Blake of Bradenton recently killed an eight-point buck while on a hunting trip in Dixie County. Dr. Blake reports that deer are plentiful in that section.

* * *

Dr. S. E. Driskell of Jacksonville was recently appointed to the State Board of Medical Examiners by Governor Doyle Carlton. Dr. Driskell's term begins December 27th.

* * *

Dr. Bascom H. Palmer and Dr. Thos. W. Hutson of Miami have returned from a hunting trip to Aiken, S. C.

* * *

Dr. and Mrs. Gilbert Osincup, who spent some time in Birmingham recently, where Dr. Osincup attended the meeting of the Southern Medical Association, visited in New Orleans before returning home.

* * *

Dr. and Mrs. E. J. Hall of Miami were recent visitors in Ft. Myers.

* * *

Dr. G. H. Edwards of Orlando was reelected president of the Central Florida Yale Club at an annual meeting held in Orlando recently.

* * *

Dr. and Mrs. W. C. Chowning of New Smyrna recently attended a state meeting held in Miami for the purpose of inaugurating a "Florida Year 'Round Club."

* * *

Dr. and Mrs. F. A. Gowdy of Miami recently visited in Moore Haven where Dr. Gowdy enjoyed a first-of-the-season hunt.

* * *

Dr. and Mrs. R. P. Henderson of Tampa were visitors in Tallahassee recently.

* * *

Dr. and Mrs. E. M. Brevard of Tallahassee attended Homecoming in Gainesville. They returned by the way of Lake City for a short visit with friends.

* * *

Drs. Louis Orr and G. S. Osincup of Orlando were in Tallahassee on professional business recently.

* * *

Dr. H. P. Bevis of Arcadia was a visitor in Boca Grande the early part of this month.

* * *

Drs. W. W. Harden and C. C. Rudolph of St. Petersburg were members of a Thanksgiving hunting party.

COMPONENT COUNTY SOCIETIES

COLUMBIA COUNTY MEDICAL SOCIETY

The annual election of officers of the Columbia County Medical Society took place after a quail supper at the Blanche Hotel, Lake City, December 12th. The officers which had served the society for 1932 were re-elected for 1933, as follows:

President—Dr. L. M. Anderson.

Vice-President—Dr. R. B. Harkness.

Secretary-Treasurer—Dr. T. H. Bates.

Dr. Anderson was selected as delegate to the annual convention with Dr. Harkness alternate delegate.

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was called to order by Dr. C. F. Roche, president, Friday evening, November 4, 1932. As a special matter of business, Mr. Walter Payne, a local attorney, spoke with reference to the proposed organization of a "Dade County Medical Clearing House, Inc." Dr. Gerry R. Holden, Jacksonville, president of the Association, was the principal speaker of the evening. Dr. Stewart Thompson, business manager, was also a guest of the society. Two scientific papers were presented: "Ulcerations of the Bladder in the Female," by Dr. John E. Hall, and "Diagnosis and Treatment of Head and Spine Injuries," by Dr. I. H. Agos.

LAKE COUNTY MEDICAL SOCIETY

The members of the Lake County Medical Society are happy over the assurance that the county is to have a strictly modern hospital for use early next year. This society has been given the free use of the north wing of the Harry-Anna Elks home at Umatilla, and they are now asking the various service clubs of the county and interested citizens to equip the rooms. The plan is to expend at least $150.00 for each room, which will provide attractive furnishings.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

At the quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held in Monticello recently, the following officers were elected:

President—B. A. Wilkinson, Tallahassee.

Vice-President—J. H. Pound, Chattahoochee.

Sec'y-Treasurer—O. G. Kendrick, Tallahassee.

VOLUSIA COUNTY MEDICAL SOCIETY

Fifty-two physicians were in attendance at the regular meeting of the Volusia County Medical Society held in New Smyrna, November 15th. The meeting was devoted to a round table discussion of state medicine.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, Inc.

State Editor

Mrs. S. E. Driskell

1410 Windsor Place

Jacksonville, Florida

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Mrs. W. W. Kirk, Finance *Jacksonville*
Mrs. J. R. Wells, Public Relations *Daytona Beach*
Mrs. H. Q. Jones, Hygeia *Ft. Myers*
Mrs. S. E. Driskell, Press and Publicity *Jacksonville*

Mrs. Eugene G. Peek of Ocala, president-elect of the State Auxiliary, represented Florida at the Southern Medical Association and we are indebted to her for the following account of the meeting:

The opening session of the ninth annual convention of the Woman's Auxiliary to the Southern Medical Association was a luncheon meeting at the Tutwiler Hotel, Birmingham, Alabama, Wednesday, November 16, 1932, and was called to order by Mrs. John M. Akin, president of the Jefferson County Auxiliary.

After the invocation by the Reverend Dr. Charles Clingman, Mrs. Akin, in a happy greeting, welcomed the guests and presented the Southern Auxiliary president, Mrs. Charles E. Oates of Little Rock, Arkansas, who took the chair. Mrs. A. A. Herold of Shreveport, La., president-elect, responded to the welcome address in a very happy manner.

Dr. L. J. Moorman of Oklahoma City, president of the Southern Medical Association, commended the work of the Auxiliary and advocated a continued interest in the history of medicine.

Mrs. J. N. Brawner of Atlanta introduced the honor guests—Mrs. L. J. Moorman, Mrs. Seale Harris, Mrs. C. P. Loranz, Mrs. J. H. Dodson, Mrs. A. T. McCormack, Mrs. C. W. Garrison, and Mrs. Southgate Leigh. The following officers were present and were recognized: Mrs. A. A. Herold, president-elect; Mrs. J. Bonar White, recording secretary; Mrs. M. J. Kilbury, corresponding secretary.

William D. Jones

Pharmacist

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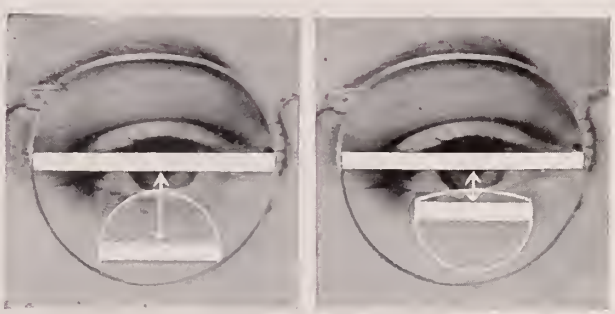
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Mrs. Seale Harris was asked to serve as parliamentarian. Committee chairmen were appointed as follows: Auditing, Mrs. Eugene Peck; resolutions, Mrs. James Brawner; budgeting, Mrs. C. M. Pounders; nominating committee in full, Mrs. James Brawner, Mrs. Estes Hargis, Mrs. A. T. McCormack, Mrs. J. D. Thompson, Mrs. W. R. Buffington.

Thanks were expressed to Mrs. Sidney Collier, chairman of arrangements, and to the entire Jefferson County Auxiliary for their gracious hospitality.

The following resolutions were adopted at the general meeting on the seventeenth:

1st. That Auxiliary members carry the Jane Todd Crawford memorial project to all women's organizations in their states.

2nd. That each state as a body pass a resolution persuading action on this memorial by the Auxiliary to the A. M. A.

3rd. That the work of research in medicine be continued.

Dr. Southgate Leigh, member of the advisory committee, brought a message which included the resolution that the Women's Auxiliaries continue active cooperation with the medical profession, and that local Auxiliaries be formed in connection with every county society.

The newly elected officers are: President, Mrs. A. A. Herold, Shreveport, La.; president-elect, Mrs. Southgate Leigh, Norfolk, Va.; first vice-president, Mrs. J. Bonar White, Atlanta, Ga.; second vice-president, Mrs. Sid W. Collier, Birmingham, Ala.

The next meeting is to be held in Richmond, Virginia.

* * *

We congratulate Pinellas Auxiliary on the article appearing in the St. Petersburg Times after their luncheon meeting of October 25th, which marked the beginning of their third year.

The article outlined the work of the Auxiliary in such a way as to be of interest and educational value to the public.

They have an unique way of holding up their attendance. They always have a luncheon meeting and they have the understanding that each member pays her luncheon fee whether she attends the meeting or not.

One plan they have for earning money to enable them to place Hygeia where it will be read is for each member to make sections of a yo-yo quilt which will be sold when it is completed.



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FALSE RUMORS CONCERNING VIOSTEROL DENIED BY DR. STEENBOCK

Ever since viosterol was offered to the medical profession about 4 years ago, it has been attacked by various persons. Some of these attacks no doubt were sincerely motivated, but others were seized upon and exaggerated by interests who had no viosterol to sell. Recently a new form of anti-viosterol propaganda has been reported by physicians all over the country. It is circulated by word of mouth—never in writing—and the apparent purpose is to influence physicians to prescribe vitamin D agencies other than viosterol.

Physicians are being told, for example, that Dr. Harry Steenbock has "condemned" viosterol, that the Wisconsin Alumni Research Foundation "would withdraw viosterol from the market in 90 days," etc., etc.

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MAY 1, 2, 3, 1933



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OF THE
Florida Medical Association, Inc.

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VOLUME XIX
NO. 7

Jacksonville, Florida, January, 1933

Yearly Subscription, $3.00
Single Copy, 30c

THE N.Y. ACADEMY OF MEDICINE
JAN 23 1933
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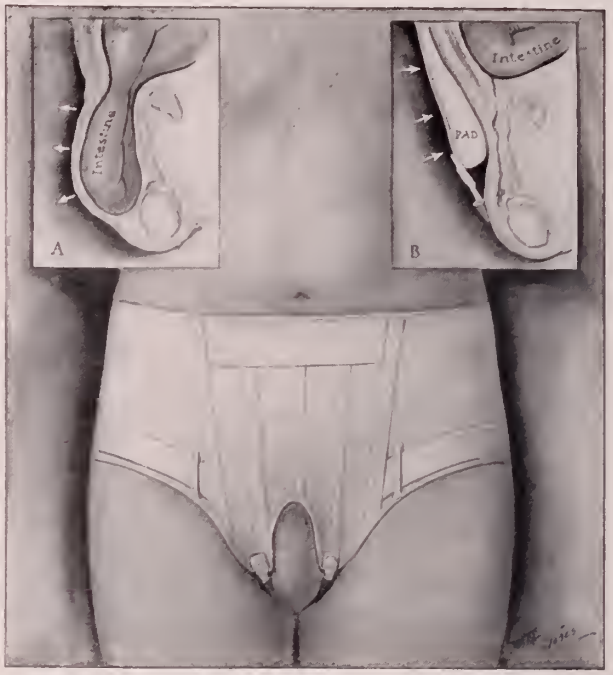
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J546

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means to enable us to take up the gauntlet which Nature has flung in our faces. Fortunately, we were able to convince the Rockefeller Foundation that Florida was the field for Mark F. Boyd, who, as you see, has come to aid us in the fight. The magnitude of his field has in a limited way, been portrayed to you tonight. Later the Surgeon General of the United States Public Health Service saw that there was ample room in the front lines of the fight for him to ally his forces with those of the State Board of Health and the Rockefeller Foundation, and detailed one of his Field Marshalls, T. H. D. Griffitts, to reconnoitre and extend his trenches to join up with Boyd's sector to present an unbroken allied front against this common foe, the lady Anopheles and the triple alliance of the plasmodii of malaria. There is also room in the fight for those of you here tonight. If you will assign a Generalissimo from the State and County Societies we will find sectors in which you can dig in and fight to your heart's content.

It is interesting to glance at the malaria history of the State as we know it from the time of the establishment of the State Board of Health. In 1890 there were 101 reported malaria deaths, 1 dengue, 1 malarial cachexia, and 7 due to jaundice. In 1891 there were 87 malaria deaths. In 1892 there were 172 malaria deaths. In 1893 there were 183 such deaths. The state population was then given as 391,452. In 1894 there were 99 reported malaria deaths. For the following five years I did not find any statement for malaria, but in the report for 1898 the total is given for the previous five years, evidently including the 99 mentioned above for the year 1894, or a total of 447 for the period. The census then gave the state population as 464,639. In 1899 there were 250 malaria deaths.

In reading the 11th annual report of the State Board of Health for the year 1899, it is interesting to note the scepticism expressed regarding "the recently propounded theories" that the mosquito is the carrier of malaria. Not more than twenty months ago a regularly licensed physician told me that many people in his vicinity had malaria because they drank swamp water.

In the 1900 Annual Report, on page 62, Dr. Porter, in discussing Vital Statistics, speaks of six principal causes of deaths. The first three of these were consumption, with 493 deaths; commenting on malaria, he alludes to the preceding twelve months as an unprecedentedly bad year with 339 reported malaria deaths, and for pneumonia 316. 1900 was the year when the new theories regarding the transmission of malaria by Anophelene mosquitoes and the transmission of yellow fever by the *"Culex fasciatus"* were brought to the attention of Dr. Porter and other health officers of the South.

On page 48 of the 12th Annual Report (1900) he wrote "Judging from the current medical literature of today, the consensus of opinion among medical men, directed by the observation and experiments of Doctors Ross, Manson, Low and other scientists, in regard to malaria, is that the organism of Laveran is a blood parasite, paludal in habits, possessing a flagellating phase; that this phase is developed from the mature parasite; that it is evolved only when the parasite is outside of the human body; that the flagella when formed break away from the parent parasite, and then, when free, the flagella are capable of living as independent organisms. The flagellum is therefore the extra-corporeal phase in the life history of the parasite, and as it is impossible for the latent form in which this organism originates to escape from the human body by itself, it is necessary to invoke the assistance of some outside agency, and the probable agent is the mosquito. The flagellated body is sucked into the stomach of the mosquito and developed therein."

In 1901 only 189 malaria deaths were reported but these were for the last seven months of the year. No reference is found regarding the first five months. In 1902, 153 deaths were reported due to malaria and 32 caused by remittent fever. In 1903, 223 malaria deaths were recorded and 8 others due to remittent fever; in 1904 there were 129 malaria deaths and in 1905, the year of the yellow fever epidemic, there were only 42 malaria deaths reported but 81 persons died as a result of yellow fever. Of 348 specimens of blood submitted for examination in the Laboratory, Dr. Andrade found only 46 positives. It is interesting to note that one case of Quartan malaria was reported in 1906.

Inasmuch as hookworm disease prevails where malaria is endemic, it is worth noting that hookworm disease was recognized in 1903 by Doctors Adamson and Helms, which appears to be the date when the State Board of Health began taking notice of ankylostomiasis. It is difficult to get results treating a malaria patient who also has hookworm disease.

Since our program this evening deals with an-

other phase of malaria to which Balfour has applied the term, "Malaria the Benefactor", a phase which Dr. Boyd has discussed, I am interested in the historical references to this phase. Professor Wagner-Jauregg[5] of Vienna began treating general paresis of the insane by inoculations of malaria about 1920; also it appears that some were treated in this way as early as 1917, but nothing was published regarding the early work. The benefits of malaria to patients with central nervous system disease appears to have been recognized by the eminent Dutch physician Boerhaave previous to 1832. In Boisseau's "Physiological Pyretology", page 402, we find the following: "Intermittent fever disposes to longevity. The fact that in a very limited number of cases, melancholy, mania, gout, epilepsy and palsy were observed to cease after its appearance has given rise to the belief that this fever might sometimes be beneficial in its effects". Balfour has suggested that this form of treatment may be applicable to other diseases of the central nervous system due to specific spirochetes. What more we do not know, but we intend to continue the research, hoping to learn. In the State Board of Health program we must first rely on individual and family protection.

While no protective measures were recognized until after the mosquito theory was proven, it seems that the Egyptian and Cretan fishermen slept under fish nets folded again and again, thinking that they kept out the miasmata. Herodotus wrote of this as a mere curiosity. Gauze was first proposed by Rougel de Lisle in 1817 and Brocchi, 1722-1786, is said to have successfully employed it against malaria. Varro, 36 B. C., and Columella, 100 A.D., about 2,000 years ago, suggested that mosquitoes were carriers of malaria fever. Richard Burton in his book, "First Footsteps in East Africa", published in 1856, states that the people of Zayla in Somaliland believe mosquito bites occasioned deadly fever. Burton thought it a superstition. In South America (Colombia), some physicians think mosquitoes are mechanical carriers of leprosy.

Balfour suggests that the ancestors of the malaria parasite were probably coccidia, tiny protozoa inhabiting the cells lining the wall of the intestine which later sought a more favorable habitat in the red blood cells.

Apparently malaria is not as widespread as it was about 50 to 75 or 100 years ago. Many pioneers from northern Europe attempted to settle along the northern third of the Mississippi River in the early sixties of the last century, but were unable to remain on account of malaria. Both my father and my father-in-law, the former along the Mississippi in Minnesota, and the latter in Illinois, suffered so much from ague that they were forced to seek the more salubrious climate of the prairies of Dakota Territory.

As you have noted from what has been said this evening and on other occasions, we are engaged in a program of detailed studies of the actual nature of malaria on one hand and on the other practical methods of control. In the study we are learning many new and extremely important facts which will have a very useful bearing on the control of this disease. Complementing this phase of the work, we are engaged in another series of studies in an effort to determine definitely the incidence of infection and the extent of the Anopheles breeding which keeps the infection going.

In this work we hope to find economical methods of control which will reduce malaria to a minimum in this state. Dr. Griffitts is launching a program of control studies which will aid in removing the shackles of ill health and poverty from our rural people, who would be self-sustaining and prosperous were they not staggering under the crushing load of malaria and hookworm disease.

Never has opportunity for scientific enlightenment been knocking on Florida's door as it is today. Dr. Boyd's great work is well under way, Dr. Griffitts' work in Florida has had its vernix caseosa removed and is taking nourishment. In addition we have Dr. W. V. King, Mr. G. H. Bradley and Mr. McNeal, three of the leading entomologists of the Bureau of Entomology of the United States Department of Agriculture established in Orlando, ready to cooperate with Boyd, Griffitts and the State Board of Health. None of this work is in any sense an infringement on the perogatives of the medical profession. It will be a valuable aid.

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COMPARATIVE VALUES OF RESPIRATORY STIMULANTS*

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Daytona Beach.

In recent years, the market has been flooded with a multiplicity of so-called new drugs, many of which make extravagant claims as to their usefulness, and lack of harmful effects. It behooves us to take notice of these new preparations, and properly evaluate them. We may then add the useful ones to our armamentarium, and discard the poor and worthless ones, continuing to use the old and tried preparations.

I have tried to find an ideal respiratory stimulant but have not succeeded thus far. However, I believe we have one, which, in the cases where it has been used, and which have been under my observation, has failed to evidence any of the disadvantages or deficiencies of most of the other stimulants.

Other stimulants commonly used by the profession, develop certain cumulative or toxic effects, when attempt is made to use them over a prolonged period or in massive doses. We will briefly outline some of the disadvantages of several drugs used to stimulate respiration.

Atropine Sulphate

Atropine produces a variety of central and peripheral effects. In small or moderate doses it acts as a respiratory stimulant, but large doses produce respiratory paralysis. It may be employed with good effect in cases where respiration is embarrassed from other causes than mechanical agents. It may thus be used in morphine poisoning. By paralyzing the vagus endings, atropine increases the rapidity of the heart-beat. Atropine diminishes the secretion of hydrochloric acid by the stomach, and so should not be continued for a long time. Secretion of sweat is reduced by atropine. It also causes disturbance of vision if given in sufficient doses.

Another drug commonly used is caffeine. It acts on the nervous system, stimulating the psychic centers, the respiratory and vasomotor centers, and the reflexes. In man, respiration is only moderately increased or scarcely affected by oral, therapeutic doses, unless cardiac dyspnea is improved. With hyperdermic injection, there is definite evidence of respiratory stimulation. CO_2 tension is markedly lowered. Rate and depth of respiration are increased. Excessive doses produce insomnia, nervousness, headache, palpitation and nausea or vomiting, restlessness, anxiety, and sometimes delirium. Toxic doses may produce tetanic convulsions and cardiac dilatation. Caffeine is useful in collapse, by causing a rise of blood pressure, and by stimulating respiration. It may be used in narcotic poisoning in the form of hot coffee.

Then there is strychnine sulphate. Strychnine stimulates the reflex activity of the spinal cord. Therapeutic doses of strychnine increase respiration mainly by acceleration. This is due to increased excitability of the center. In toxic doses it produces tonic convulsions similar to tetanus, and respiration is spasmodic and arrested during the tetanus. It has been widely used as a respiratory and a circulatory stimulant in pneumonia and other infections, shock, etc., but careful observations have shown that non-toxic doses are ineffective.

Of the newer preparations, there are two that I have used. The first is called coramin, and is claimed to be useful in acute circulatory failure, and respiratory depression. In circulatory failure, I have found it useful, but not more so than camphor-in-oil. As a respiratory stimulant, I have not had any success with this drug.

One of the new drugs is alpha-lobeline. It has been used in numerous cases under my observation, and apparently is free from many of the harmful effects of other stimulants. With adults or infants, this drug may be used over a prolonged period and in massive doses. It is the hydrochloride of the principal alkaloid of Lobelia inflata, a plant indigenous to North America. This herb was used by the American Indians as a substitute for tobacco. It was introduced into medicine by Samuel Thompson about the beginning of the nineteenth century as the main basis of his peculiar system of treatment. Lobeline seems to be a specific. It directly stimulates the respiratory center and lowers the CO_2 threshhold. Sollman states it raises the blood pressure slightly.

Among the cases in which I have used this drug, are the following:

Case 1.—A male infant 22 months old, weight

*Read before the 4th Annual Meeting of the Florida East Coast Medical Association, Jacksonville, Oct. 28, 29, 1932.

23 pounds. Temperature 104 degrees. This patient had a convulsion lasting three hours. With high colonic irrigations, the convulsion gradually subsided. In a few hours, he had another convulsion, and his respirations ceased. Artificial respiration was begun, but the patient responded very poorly. His condition remained the same throughout the day, with convulsions every 2-3 hours. His respirations ceased with every convulsion. The night of the second day, we started alpha-lobeline, without using artificial respiration. In eight hours, we used twelve times the adult dose, with no apparent ill effects. On the third day a spinal tap was done, and the spinal fluid pressure found to be 20 millimeters of mercury. The pressure was relieved, and the child made an uneventful recovery.

Case 2.—A white male adult, about thirty-six years of age. Operated upon for acute appendicitis. During the course of the anesthetic, he ceased to breathe, and all sphincters relaxed. The pulse was absent. He was given one ampoule alpha-lobeline, and artificial respiration was begun. In one and one-half minutes, he breathed normally and continued so throughout the course of an anesthesia.

Case 3.—A premature infant, seven and one-half months, weight one and one-half pounds. Because of a placenta previa, the mother bleeding and in early labor, a Caesarian section was done. Baby delivered without undue delay, but ordinary methods of resuscitation to start breathing failed. One ampoule alpha-lobeline—adult size—was given, in the umbilical vein. In fifteen minutes, another ampoule was given. This was continued without any other attempts at resuscitation, for six hours, when the baby expired.

We have used alpha-lobeline in cases of drowning, and in one case of poisoning from an overdose of morphine, with apparently beneficial results.

In briefly summing up our results, I believe we have a drug that will help in cases of respiratory failure. We, of course, do the necessary things for the patient, such as cleaning the throat of mucous, the lungs of water, etc., and administer artificial respiration, but I believe that alpha-lobeline does hasten the period when normal respiration begins.

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PRACTICAL ESTIMATION OF RENAL FUNCTION*

D. Paul Bird, M.D.,
Lakeland.

The physicians in the field of medicine and surgery are beginning more and more to realize the value of an accurate estimation of the renal function, both in health and disease. No longer is a surgeon's trust placed solely in a urine analysis. He also wishes to know the reserve power, or the flexibility of the kidneys. He asks himself, "Will they or will they not stand the added burden they must bear? Am I justified in placing an additional load upon a healthy kidney, or is the kidney diseased and unable to stand the shock of a surgical operation?" Such an operation might be a complete nephrectomy, a partial operation upon the kidney, a prostatectomy or any of the numerous major surgical procedures in which shock would play a prominent part.

The kidney is the sole organ whose purpose is to form and secrete urine. Urine is a liquid vehicle for the removal of waste substance. Such substances are water, inorganic materials, and the products of protein metabolism or nitrogenous materials. The main elements are urea, purine bodies, creatine, oxalic acid, conjugated sulphates and glycerates, aromatic oxacids, nitrogenous acids, fatty acids, dissolved gases, N and CO_2, urochrome, and urobilin. The exact mechanism, whereby the kidney accomplishes the elimination of these substances in the formation of urine, is not clearly understood. As a result, there has been much confusion and many theories of this physiological process. We do know, however, that the blood vascular system is linked intimately with renal mechanism, and that the blood carries these waste substances in a state ready for excretion while the kidney in turn helps regulate the acid-alkali reaction of the blood.

It is the aim of every kidney function test to measure the efficiency of the kidney to eliminate solids in a watery solution. Inasmuch as this is a complicated, complex problem, many factors may prevent such tests from being accurate and exact. The fault with most such tests is that they do not give any indication of the reserve power or flexibility of the renal substance, (experimentally 2/3 of the working kidney substance may be removed without the blood urea increas-

*Read before the DeSoto-Hardee-Highlands County Medical Society, Sebring, June 14, 1932.

ing). Neither does any such test do more than indicate the present activity, rather than a future ability to perform under more trying circumstances.

In urological surgery, an estimation of the renal function is absolutely necessary. Present-day methods are not infallible but some of them give a fair indication of the ability of the kidney to carry on under the added strain of such an operation as proposed. And our interest now is in the more practical and reliable methods within the reach of the average physician and surgeon.

The first one to be considered is the 24-hour output. This method has its chief value in medicine. In cardiovascular renal disease, one finds a nocturia, generally associated with edema. The 24-hour output is proportional to the weight, about 25 cc. per kilo in the adult. An average output of 1200 to 1800 cc. does not tell much, but below 800 cc. indicates oliguria, and more than 2500, a polyuria. All fluid intake must be measured and compared with the output. The output varies directly with the intake, also with the substances to be excreted, and the loss by perspiration. Addis has shown that oliguria due to renal causes is characterized by a too small increase with more fluid, and a too great a volume with limitation of fluid.

The 24-hour concentration of urea is an estimation of nitrogenous bodies, and, on a mixed diet, the amount excreted is the same as the amount ingested. Urea forms 80% of the nitrogenous output or about 14 gms. in 24 hours. To be of value the intake must be compared with the output and measured for 24 hours or longer. The urea output varies also with the fluids and in a diseased kidney more fluid would give a low concentration; while a high concentration would indicate evidence of health. Nervous individuals often excrete large amounts of fluids and subsequent low concentration. Because of its variability, such a test is valueless as an estimation of total renal function. However, the urea estimation from the separate catheterized kidneys is frequently used and serves to check on a phenolsulphonephthalein, where leakage may be suggested around the catheters. This test is read in per cent of urea and each kidney should not vary more than 5% or 1 gm. in 20.

Van Slyke's method of the urea clearance time is the best test for the pre-eclamptic and low reserve kidney but the time and cost prevents its practicable application in the office as routine procedure. Studies of specific gravity vary so much as to become of questionable value in the majority of cases. Tests for creatine and chlorides have value but are complicated and require elaborate technic. In view of these facts such tests are not widely used except in large clinics where complete laboratory facilities are readily available. Blood urea determination is of definite value in tests for retention of nitrogenous products. Normal urea concentration, generally read as urea nitrogen, should be within 12 to 15 mg. per 100 cc. of blood. 30 mg. is dangerous. Any accumulation beyond this is evidence of retention due to renal insufficiency.

Phenolsulphonephthalein or phthalein or P. S. P. elimination deserves its popularity, as a test of renal function; because of its *simplicity* and *relative accuracy*. This dye can be used by anyone who can give an intravenous injection, and its results are correspondingly easy to read. The injection can be given either intravenously or intramuscularly. The intravenous method takes only half the time of the intramuscular route and at the present time is the most popular method. Before administration of the dye, the bladder is emptied either by voiding or catheterization. 1 cc. of a 6% solution monosodium phenolsulphonephthalein is given by vein. Two specimens are then collected, one the first ½ hour, another the second ½ hour. The dye usually appears in from 2 to 5 minutes and eliminates 40 to 50% in the first 15 minutes, 10 to 20% in the second 15 minutes. At the end of ½ hour, the first specimen is collected and should read between 40 and 60%. Hardly more than 10 to 15% of the dye is ever eliminated from a healthy kidney in the second half hour. If the dye is given intramuscularly, the specimens are collected at 1-hour and 2-hour periods. The 1-hour period here closely approximates the ½-hour period of the intravenous method.

In renal disease, there is a delay in the excretion and output of the dye. Acute infections are the exceptions. The chronic renal cases can thus be detected long before the increase in blood urea and almost as soon as the 24-hour water test. Sometimes, however, the dye will not appear for ½ hour or longer, but then puts out a good percentage. In such cases, the delay is not so important as the ability to cencentrate it when it is excreted. A doubtful return would best be repeated. Other errors may be caused

by anesthesia, narcotics or possible obstruction. Faulty technique due to failure to empty the bladder, may be another source of error.

Separate or relative renal function is made by cystoscopy and ureteral catheterization. The dye is collected from each kidney and a 15-minute estimate made. A normal kidney will return 1% phthalein per minute for the first 15 minutes. This method is the most accurate one now in use, and may be made even more so by a comparison with a total phthalein made beforehand. The dye reaches both kidneys at the same time and a comparison of the related function will serve to differentiate between the normal and diseased organ. It is found that after nephrectomy, very often the remaining kidney hypertrophies, and carrying on the function of both will give a normal phthalein output. Repeated low returns of phthalein are of more significance than elevated blood urea. If the return for the first half hour is under 20%, the test should be repeated. If the returns are again low, a blood urea is indicated. When the phthalein output is normal a blood urea retention test will not give any additional information but when the phthalein is low, the blood urea will often give the needed information. A low phthalein with a normal urea is of less significance than a low phthalein with retention of these substances. In all cases in which a determination of renal function is indicated a phthalein should be performed. This may be followed by a blood urea. If the blood urea is low then cystoscopy and ureteral catheterization will give the information as to which kidney is at fault.

Many renal function tests are in use but the majority of medical men prefer the information given by the more practical and accurate use of phenolsulphonephthalein; however, there is still considerable difference of opinion and individual preference.

THE NEXT MEETING
OF THE
FLORIDA MEDICAL
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MAY 1, 2, 3, 1933

THERAPEUTICS*

(With Appropriate Apologies)

ROBERT H. MCGINNIS, M.D.,
Jacksonville.

Open your therapeutics—study a page or two,
'Twill benefit your patient and it may be good for you.

Much you read is inapropos, more is good by far;
Consider the subject matter, take the best at par.

It may be an ancient issue, it might be a late edition;
Fortify your mind with facts and better your patient's condition.

Study physiologic actions, apply therapeutic tests,
Rely on good authority, expect results with zest.

Physiologic actions vary, therapeusis causes suspense;
Idiosyncrasies considered, use some common sense.

Do not blame the drug if the patient is not improving,
Consider your diagnosis, errors may need removing.

Open your therapeutics, all covered with dust and brown;
Peruse its pages early and after the sun goes down.

Such perusal will give you comfort, perhaps will give you rest,
When the patient is quietly sleeping from a therapeutic test.

Many a doctor has floundered on the rocks of proprietaries,
Swallowing "hook, line and sinker" of the detail Luminaries.

The detail man talks glibly of a vaunted panacea;
Consult your therapeutics, each statement test in clear.

Let each and every ingredient stand the test of science;
Study your therapeutics for that's the best reliance.

It's elixir this, and elixir that, and syrups forty or more,
Many extracts, cure-all tonics and mixtures by the score.

Of incompatable, inert drugs, antagonists and junk;
Of sedatives and concoctions all of which are punk.

Of pluriglandular formulas, "He would a tale unfold,"
The therapeutic effects of which would "Harrow(er) up thy soul."

He praises his firm's productions, good for what may ail you;
Prescribe it in original packages, 'tis all you have to do.

The detail man has a thing to sell, he has a wage to earn,
He's paid to talk his line of goods, but has a lot to learn.

Treat him kindly, courteously, thank him for his toil,
But review your therapeutics and "burn the midnight oil."

Open your therapeutics and read its pages through,
Here's a potent alkaloid and several sera, too.

Which is the better agent, concoctions of many kinds,
Or a number of active principles, fifty kept in mind?

Councillors active and potent, comforters helpful, true;
And never a one of the fifty to negative the faith in you.

Use them with discretion, from all select a few,
If diagnosis is correct, they'll aid and comfort you.

*Published in the July, 1927, Journal, F. M. A., but deemed worthy of repetition.

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this Journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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THIRTEENTH DISTRICT—JOHN S. HELMS, JR., M.D. . . Tampa
Hillsboro.
FOURTEENTH DISTRICT—D. A. McKINNON, M.D. . . Marianna
Calhoun, Jackson, Gulf.
FIFTEENTH DISTRICT—E. M. HENDRICKS, M.D. . Ft Lauderdale
Palm Beach, Broward.
SIXTEENTH DISTRICT—W. L. ASHTON, M.D. . . . Umatilla
Sumter, Lake.
SEVENTEENTH DISTRICT—MEREDITH MALLORY, M.D. . Orlando
Osceola, Orange.
EIGHTEENTH DISTRICT—JOSEPH HALTON, M.D. . . . Sarasota
Manatee, Sarasota.
NINETEENTH DISTRICT—HENRY P. BEVIS, M.D. . . . Arcadia
DeSoto, Hardee, Highlands.
TWENTIETH DISTRICT—WILLIAM R. WARREN, M.D. . Key West
Monroe.
TWENTY-FIRST DISTRICT—H. D. CLARK, M.D. . . Ft. Pierce
St. Lucie, Okeechobee, Indian River, Martin.

COST OF MEDICAL CARE

Two years ago Einstein, and his theory of relativity were hailed and acclaimed as the world's greatest. Space writers, editors, journalists and lay individuals wrote voluminously about the theory, extolling its creator. But today many a scientist of note admits—with reluctance, 'tis true—that even Einstein cannot explain his theory so they can understand it. This is much the status of the committee on the Cost of Medical Care and its findings. We have the report and we also have writings everywhere, both doctors

and laymen commenting on and explaining it, and many whether they know of its provisions or not. However, the committee itself cannot tell how the report should be interpreted nor what the results of an attempted adoption would be. In a very blasé way the majority report states that "a continuing organization may be formed to carry on experiments," to see if their theory will work.

Of course there are many angles from which the findings may be viewed. After a careful reading, instead of having the cost question clarified, one's mind is in more confusion than ever. The statements and deductions do not lead to confidence, unless one is of a communistic frame of mind. In some small, somewhat isolated communities, when there is but one hospital and all the physicians are willing to cooperate, certain suggestions as made by the minority, reassessments for all inhabitants or a sort of group health insurance might be worked out, but to the advantage of the indigent only, since their policies would have to be paid for by the city or county government. The physician and those desiring special attention would both be the losers.

We are constrained to believe that the best interest of medicine, and the public, will be served by pigeon-holing the whole report. We further are constrained to believe that each community should take care of its own medical indigent by the organization of a full-time county health unit, which the Florida Legislature has already authorized. Each unit should employ enough physicians to handle all indigent sick; indigency being determined by a welfare investigating group. If a county or city hospital exists, those needing hospitalization can well be taken care of, but when no county hospital is available, those needing hospitalization should be cared for in private institutions at a substantial, patient per diem rate.

Those not indigent should still be permitted—shall I say by our paternalistic government—to employ the physician they deem best fitted to meet their needs. The rich can pay—some of them do not—thus the rich are cared for. The great group of people in moderate circumstances, if they will but take their family physician—and every family should have one—into their confidence, can have all the attention needed at a fair price. True disciples of Æsculapius are ever charitable—thus the moderate circumstanced are cared for.

ELECTION OF OFFICERS

The time is at hand when we are confronted with the necessity of choosing the men who will guide us through the ensuing year. In this selection lies our opportunity to make the year a profitable, progressive one or one in which we simply mark time.

Relentlessly time marches on taking its toll, often securing the most valuable, from the ranks in every plane of activity, social, business, professional and even from bootleggers and philanthropists. But the need for work, for persistent efforts in every walk of life still remains. The mental picture we may paint of our desires, wishes and hopes are but poor frozen visions, without strong personalities cooperating to make them warm and human. Everywhere the strong man is in demand, especially of the type who accepts responsibility and carries on to the best of his ability, always without friction, even when his views may be somewhat divergent from the views of those whom he is assisting; one who will continue to play, even if not in the van; one whose allegiance to a cause is willingly given and actively carried out. No Ajax is needed or desired. Every cause for success needs support and especially a united support with strength, willingness and well founded knowledge of its aims. The meteor is of no moment, brilliant as one sometime may be. Of greater value is the pale, never-failing, Polar Star.

The Florida Medical Association and its component parts need men of the latter type, strong, steady men, in office; men who know of its history and its value to the needy patient, as well as to the professional brother. We have always had such men within our membership in the past and will have in the future, men not self-seeking, but willing workers for others, as well as self. The steady growth of the Florida Medical Association in the past fifty years has been due to such men and there are many more like them now available. Many of those who for years have given of themselves, of their time and of their vision have passed onward. Many of those who now are intensely interested and willing servants of our society will soon take the trail "off to the end of somewhere," a road we all must claim.

There is in many groups a feeling that the so-called Jeffersonian principle (is that democratic?) of rotation in office, should be followed. This is especially so in county medical societies,

where a man serves a term in one or more offices, usually headed for the presidency and when that goal is reached, he often drops from sight.

When it comes to electing a man to the office of delegate to the state association, frequently little thought is given, anyone who has not previously served may have the office. Thereby a great error is committed. This group is the law-making body of the State Association. Its members, selected from each county society in proportion to membership, should be men who are of the type described, that is, willing workers who will give of themselves and of their time to the consideration of our needs and those of the county societies. When these men are found and inducted into office, let us keep them there, where their talents may be drafted for the benefit of the whole group. With the present tendency toward State Medicine and toward the commercializing of medical practice, whether through the guise of health insurance or like the veterans' bureau, flagrantly open, men of clear vision and love of achievement are needed. Elect such as your delegates.

CONSTITUTION AND BY-LAWS

Below appear the amended Constitution and By-Laws as approved at the meeting of the House of Delegates, May 3, 1932, and which are ready for final action at the annual meeting to be held in Hollywood, May 1st to 3rd, 1933.

At the annual meeting last year, mimeographed copies of the proposed changes were put in the hands of all the members of the House of Delegates and others who were interested. Official action was taken, approving the changes contained in the outline below. To alter our Constitution, it is necessary to pass on the changes one year and take final action the following year. The Constitution and By-Laws appearing in this issue are, therefore, ready for final action at our next annual meeting:

CONSTITUTION

Article I.

Name of the Association

The name and title of this organization shall be the Florida Medical Association, Incorporated.

Article II.

Purposes of the Association

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar Associations in other States to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of State medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

Article III.

Component Societies

Component Societies shall consist of those county medical societies which hold charters from this Association.

Article IV.

Composition of the Association

Section 1. This Association shall consist of Members, Delegates, Honorary Members and Guests.

Sec. 2. *Members*—The members of this Association shall be the members of the component county medical societies.

Sec. 3. *Delegates*—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

Sec. 4. *Honorary Members* — Honorary and retired members of the Florida Medical Association may be elected by the House of Delegates or by the Executive Committee either directly or upon nomination officially made by a component County Medical Society. An honorary or retired member shall be exempt from all dues in this Association; shall not have the right to vote; shall be permitted to subscribe for the publication of the Association at a special price to be made by the House of Delegates or Executive Committee; shall have the right to attend meetings and be eligible to such other privileges as may be granted by the House of Delegates.

Sec. 5. *Guests*—Any distinguished physician may become a guest during any Annual Meeting upon invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that Meeting.

Article V.

House of Delegates

The House of Delegates shall be the legislative and business body of the Association, and shall consist of (1) Delegates elected by the component county societies, and (2), *ex-officio*, the officers of the Association as defined in this Constitution.

Article VI.

Meetings and Sessions

Section 1. The Association shall hold an Annual Meeting during which there shall be held daily not less than two Sessions which shall be open to all registered members, delegates, honorary members and guests.

Sec. 2. The Association shall hold an Annual Meeting at the place selected by the House of Delegates at the preceding Annual Meeting. The date shall be fixed by the Executive Committee with the approval of the Committee on Arrangements of the entertaining society at least four months in advance.

Sec. 3. Special Meetings of either the Association or the House of Delegates may be called by the President.

Article VII.

Officers

Section 1. The Officers of this Association are to be a President, a President-elect, three Vice-Presidents, a

Secretary, a Treasurer, and an Editor of the Journal. In the discretion of the Association, the offices of Secretary, Treasurer and Editor of the Journal may be held by one individual.

Sec. 2. All officers are to be elected annually, and shall serve until their successors are elected and installed.

Sec. 3. The Officers of this Association shall be elected by the Association at noon on the last day of the Annual Meeting, and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer and Editor of the Journal) and who has not been a member of the Association for two years.

Sec. 4. The Journal of the Florida Medical Association, Inc., shall be the official organ of the Association.

Article VIII.

Arrangement for Funds

Funds for meeting expenses of the Association are to be arranged for by the House of Delegates, by an equal per capita assessment on each county society to be fixed by the House of Delegates, or by voluntary contributions or bequests, and by profits of publications. Funds may be provided by the House of Delegates to defray the expenses of the Annual Meetings, for publications, and for such other purposes as it may deem proper.

Article IX.

Referendum

The General Session of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may by a similar vote of its own members, or after a like vote of the General Session, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question, and be binding upon the House of Delegates.

Article X.

The Seal

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

Article XI.

Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Meeting, provided that such amendments shall have been presented in open session at the previous Annual Meeting, and shall have been sent officially to each component county society at least two months before the meeting at which final action is to be taken.

BY-LAWS

Chapter I.

Membership

Section 1. All members of Component Societies shall be privileged to attend all sessions and take part in all of the proceedings of the Annual Meeting, and shall be eligible to any office within the gift of the Association.

Sec. 2. The name of a physician upon the properly certified roster of members, or list of delegates, of a component society which has paid its annual assessment, shall be *prima facie* evidence of his right to register at the Annual Meeting in the respective bodies of this Association.

Sec. 3. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take any part in any of its proceedings until such time as he has been relieved of such disability.

Sec. 4. Each member in attendance at the Annual Meeting shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of an Annual Meeting until he has complied with the provisions of this section.

Chapter II.

General Sessions

Section 1. The General Sessions shall include all registered members, delegates, honorary members and guests, who shall have equal rights to participate in the proceedings and discussions and, except honorary members and guests, to vote on pending questions. Each General Session shall be presided over by the President, or in his absence or disability, or by his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual oration, and the entire time of the Meeting so far as may be shall be devoted to papers and discussions relating to scientific medicine.

Sec. 2. The General Session shall have authority to create committees or commissions for scientific investigations of special interest and importance to the profession and public, and to receive and dispose of reports of the same; but any expense in connection therewith must first be approved by the House of Delegates or the Executive Committee.

Sec. 3. Except by special vote, the order of exercises, papers and discussions as set forth in the official program shall be followed from day to day until it has been completed.

Sec. 4. No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject.

Sec. 5. All papers read before the Association shall be its property. Each paper shall be deposited with the Secretary when read.

Chapter III.

House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Meeting of the Association, and shall so fix its hours of meeting as not to conflict with the first General Session of the Association, or with the session held for the address of the President and the annual oration, and so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the Association and profession require, it may meet in advance, or remain in session after the final adjournment of the Annual Meeting, or meet at the call of the President.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every 20 members, and one for each major fraction thereof, but each county society holding a charter from this Association, which has made its annual report and paid its assessment as provided in this Constitution and By-Laws, shall be entitled to one delegate. Provided, that this annual report must be made to the Secretary of the State Association at least thirty days prior to the date of the Annual Meeting.

Sec. 3. A majority of the registered delegates shall constitute a quorum, and all of the sessions of the House

of Delegates shall be open to members of the Association.

Sec. 4. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county of the State who can be made reputable has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body in such a manner that not more than one-half, as near as may be, shall be elected in any one year.

Sec. 9. It shall, upon application, provide and issue Charters to County Societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 10. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies, and these societies when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 11. It shall divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of component county societies, and no other, shall be members in such district societies.

Sec. 12. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates, and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Sec. 13. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 14. It shall publish its proceedings in The Journal of the Florida Medical Association, Inc.

Sec. 15. It shall select the place for the next annual meeting.

Chapter IV.

Election of Officers

All elections shall be by secret ballot, unless there is but one nominee for an office when the Secretary, upon motion duly seconded and carried, is empowered to cast the ballot of the Association for the nominee. A majority of the votes cast shall be necessary to elect.

Chapter V.

Duty of Officers

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged; shall give a deciding vote in case of a tie, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the State and assist the Councilors in building up the county societies, and in making their work more practical and useful.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the First Vice-President shall succeed him. The President-elect shall be *ex-officio* member of all committees, without the power to vote.

Sec. 3. The Treasurer shall give bond in the amount of his yearly budget. He shall demand and receive all funds due the Association, together with bequests and donations, and shall have the care and arrangement of fiscal affairs of the Association. He shall subject his accounts yearly to audit by a Certified Public Accountant, and render an annual report of his doings to the second General Session of the Association. He shall charge upon his books the assessments upon each component County Society at the end of the fiscal year, which assessments he shall collect and make the proper credits for, and he shall perform such other duties as may be assigned to him. All funds belonging to the Association shall be deposited in a National Bank to the credit of the Association. No money shall be drawn from this account except by proper voucher checks, serially numbered. The expenses of the Treasurer's bond and audit of accounts, shall be paid by the Association.

Sec. 4. The Secretary shall attend all sessions of the Association and of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall provide for the registration of members and delegates at the Annual Meetings. He shall keep a record of all the legal practitioners of the State, noting their status in relation to their county societies, and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power, he shall use the printed matter, correspondence and influences of his office to aid the Councilors in the organization and improvement of the county societies and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He may employ such assistance as may be authorized by the House of Delegates or the Executive Committee. He shall annually make a report of his doings to the second General Session of the Association. In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be $600.00 per annum.

Chapter VI.

Council

Section 1. The Council shall consist of one Councilor from each of the twenty-one councilor districts, to be appointed by the President. The President shall annually appoint a Chairman and a Secretary and the latter shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the second General Session of the Association.

Sec. 2. Each Councilor shall be organizer, peacemaker and censor for his district. He is urged to visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of

his doings, and of the condition of the profession of each county in his district to each annual session of the Council.

Sec. 3. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates, or the general sessions, must originate in the county society and shall be referred to the Council without discussion.

Chapter VII.

Committees

Section 1. Regular Committees shall be the Executive Committee, a Committee on Scientific Work, a Committee on Legislation and Public Policy, a Committee on Publication, and a Committee on Medical Education and Hospitals. They shall be appointed by the President. The Committee on Arrangements shall consist of the component society where the annual session is to be held.

Sec. 2. The Executive Committee shall consist of the President and Secretary, *ex-officio*, and three members to be appointed by the President. It shall consider and act upon all matters of business pertaining to the Association in the interval between the Annual Meetings, and shall render a report of its actions to the second General Session.

Sec. 3. The Committee on Scientific Work shall consist of three members appointed by the President. It shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions in the Constitution and By-Laws. It shall prepare and issue a program for each Annual Meeting, announcing the order in which papers, discussions, and other business shall be presented. The number of papers to be read before each Annual Meeting shall be left to the discretion of the Committee on Scientific Work but no member shall be permitted to present a paper in successive years.

Sec. 4. The Committee on Legislation and Public Policy shall consist of three members and the President and Secretary. Under the direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of the public health and of scientific medicine. It shall keep in touch with professional and public opinion shall endeavor to shape legislation so as to secure the best results for the whole people, and shall utilize every organized influence of the profession to promote the general influence in local, state and national affairs and elections. Its work shall be done with the dignity becoming a great profession and with that wisdom which will make effective its powers and influence. It shall have authority to be heard before the entire Association upon questions of great concern at such time as may be arranged during the Annual Meeting.

Sec. 5. The Committee on Publication shall consist of the Editor and two others to be appointed by the President, and shall have referred to it all reports on scientific subjects and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication may be returned to the author. All papers read before the Association shall be the property of the Association. The Editor shall receive an annual salary of $600.00, provided that this be paid out of the funds of The Journal.

Sec. 6. The Committee on Arrangements shall consist of the component society in the territory in which the Annual Meeting is to be held. It shall, by committees of its own selection, provide suitable accommodations for the meeting-places of the Association and of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall make additional announcements during the meeting as occasion may require.

Sec. 7. The Committee on Medical Education and Hospitals shall consist of three members to serve; one for a period of three years, one for two years, and one for one year, the vacancy created each year being filled by appointment to serve a three-year term. This Committee shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

Chapter VIII.

Assessments and Expenditures

Section 1. An assessment of $10.00 per capita on the membership of the component societies is hereby made the annual dues of the Association, of this amount $3.00 shall be set aside as a subscription for The Journal. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, lists of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association thirty days in advance of each Annual Session.

Sec. 2. Any county society which fails to pay its assessment, or make the reports required, on or before the date above stated, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 3. All motions or resolutions appropriating money shall specify a definite amount, or so much thereof as may be necessary for the purpose indicated, and must be approved by the House of Delegates on a call of the ayes and noes.

Sec. 4. Any county society shall have authority to remit the dues of its Secretary, to the State Association, for duties performed in accordance with the Constitution and By-Laws.

Chapter IX.

Rules of Conduct

The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter X.

Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts' Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XI.

County Societies

Section 1. All county societies now in affiliation with this Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, upon application to the Council, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.

Sec. 3. Charters shall be issued only upon the approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or the spirit of this Constitution and these By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the District if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may

be made to the Council, which shall decide what action shall be taken.

Sec. 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable white and legally registered physician who is practicing, or who will agree to practice, non-sectarian medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right of appeal to the Council which, upon a majority vote, may permit him to become a member of an adjacent county society.

Sec. 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component society moves to another county in this State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Sec. 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official position and other preferments shall be unstintingly given to such members.

Sec. 12. At the time of the annual election of officers each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each twenty members or major fraction thereof, and the secretary of the society shall send a list of such delegates to the Secretary of this Association, at least ten days before the Annual Sessions.

Sec. 13. The Secretary of each county society shall keep a roster of its members, and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, thirty days in advance of each Annual Meeting, and at the same time that the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Chapter XII.

Amendments

These By-Laws may be amended at any Annual Meeting by a majority vote of all the delegates present at that meeting after the amendment has laid upon the table for one day.

CORRESPONDENCE

A Resolution*

To the Secretaries of the County Medical Societies:

The following resolution was passed by the Fulton County and Cobb County (Georgia) Medical Societies at their regular meetings a few weeks ago after the reading of a paper entitled "The Economic Status of the Medical Profession," which appeared later in the Journal of the American Medical Association, October 15, 1932, page 1358, under the Department of Medical Economics.

Since this article appeared we have had numerous letters from physicians all over the United States urging that this plan be placed before the different county, state and national societies for their consideration and adoption.

We are asking that you place this or a similar resolution before your society and ask for its adoption. Have it signed by your proper officials and forward to the secretary of the Medical Association of your state.

These resolutions will be placed in the hands of the delegates to the American Medical Association at its next annual meeting.

RESOLUTION

Whereas, the medical profession of the United States is suffering losses all out of proportion to its ability to endure, and

Whereas, our losses are not so much due to the financial depression as to over-production of doctors and decreased demand for paid medical service generally, and

Whereas, the production of doctors is far in excess of the population increase,

Therefore, we, the members of the..... County Medical Society, respectfully request the Medical Association of....., the other State Medical Associations, the Southern Medical Association and the American Medical Association to adopt this or similar resolutions requesting the Medical Colleges of the United States to reduce the number of graduates each year until the law of supply and demand has been fully complied with. The number of graduates to be determined by a national committee appointed by the President of the American Medical Association. Respectfully submitted,

....., M. D., President;

....., M. D., Secretary.

*Forwarded by B. T. Beasley, M.D., Atlanta, Ga.

December 6, 1932.

To the Presidents, Secretaries, and Chairmen of Legislative Committees of State Medical Associations:

A large and apparently increasing number of patients are requiring medical, nursing, and hospital service because of injuries received through the fault or neglect of other persons. These patients generally have lawful claims against the persons through whose fault or neglect they were injured and many of them are entitled to accident insurance money.

Laws have been enacted in six States that enable physicians, nurses, and hospitals to establish liens for the value of the services they render such patients, on money due them because of their injuries. After such a lien has been established, the responsible person or insurer who pays the patient's claim without satisfying himself that the bill of physician, nurse, or hospital by whom the lien was established has been paid is himself liable for payment of the bill.

A draft of an act to enable physicians, nurses, and hospitals to establish liens such as are described above is enclosed. The language of the draft has been made broad, because it will be easier for anyone wishing to eliminate what seem to him to be undesirable provisions to eliminate them if such provisions are brought to his notice, than it would be for him to discover, frame, and insert possibly desirable provisions if they had been omitted from the draft. Obviously, it is impossible to prepare a draft of this kind in a form suitable for introduction into the legislature of any particular State. Any such draft should be examined by competent counsel and modified to meet local needs and policies before it is introduced.

This matter is called to your attention solely for your consideration and such action, if any, as you deem proper. Certainly the question whether in any particular State there is need for such legislation and the question whether there is a reasonable likelihood of procuring its enactment if it is introduced, are questions for local determination.

An analysis of existing medical, nursing, and hospital lien laws is enclosed. Additional copies of the accompanying draft of a proposed bill and of the analysis of existing lien laws will be furnished on request. Yours truly,

(Signed) Wm. C. Woodward, Director.
Bureau Legal Medicine and Legislation, A.M.A.

STATE NEWS ITEMS

Dr. B. D. Epling of Lake Wales has reopened his office in the Rhodesbilt Arcade. His many friends will be glad to learn that he has sufficiently recovered from his recent illness to resume practice.

* * *

Dr. W. P. Duncan of Tampa was a member of a hunting party which went into the Gulf Hammock region the early part of December.

* * *

Dr. W. O. Arnold of West Palm Beach has returned from a four weeks' vacation spent in Georgia and North Carolina.

* * *

At a meeting of the staff of the Halifax Hospital, Daytona Beach, held on the evening of December 14th, Dr. Raymond Howe was appointed chief of staff. Dr. H. L. Merryday has served in this position for the past year.

* * *

Dr. C. W. Larrabee of Bradenton has returned to practice after several months' illness. His office is located in the Bradenton General Hospital.

* * *

Dr. Ernest B. Milam of Jacksonville attended the annual county inter-club meeting of Kiwanis held at Lakeland in December. Dr. Milam is district governor of Florida Kiwanis.

* * *

Dr. J. D. Griffin of Lakeland was elected president of the staff of the Morrell Memorial Hospital at an annual meeting held in December. Dr. Herman Watson was chosen vice-president and Dr. G. C. Overstreet, secretary-treasurer. Members of the advisory board elected were: Drs. G. C. Overstreet, H. M. Richards, R. R. Sullivan, W. L. Tillis and Walter Weed.

* * *

Dr. A. L. Stebbins gave a talk on "The Conservation of Health" at a recent meeting of the Punta Gorda Rotary Club.

* * *

Dr. W. C. Page of Cocoa recently addressed the Community Woman's Club. He spoke on the prevention of communicable diseases among school children and children of pre-school age.

* * *

The many friends of Dr. J. F. Cranford of St. Petersburg, will regret to learn of the recent death of his wife.

The Southeastern Surgical Congress announces its fourth annual assembly, Atlanta Biltmore Hotel, March 6, 7 and 8, 1933. The following prominent surgeons and internists will appear on the program:

Dr. Tom G. Orr, Kansas City—"The Essential Factors in the Treatment of Acute Peritonitis."

Dr. Walter E. Sistrunk, Dallas—Subject to be announced later.

Dr. C. W. Roberts, Atlanta—Subject to be announced later.

Dr. Geo. W. Crile, Cleveland—"Peptic Ulcer" —Lantern Slides.

Dr. W. D. Haggard, Nashville—Toastmaster.

Dr. Chevalier Jackson, Philadelphia—"Diverticula of the Esophagus and Hypopharynx." Lantern and Motion Picture Demonstration.

Dr. Charles Bagley, Jr., Baltimore—Subject to be announced later.

Dr. W. E. Lower, Cleveland—"The Various Functions of the Tests; an Experimental and Clinical Report."

Dr. Hugh Cabot, Rochester—Subject to be announced later.

Dr. Hubert A. Royster, Raleigh—"Sidelights on the Pathology of Appendicitis."

Dr. E. W. A. Ochsner, New Orleans—"The Relative Value of Sclerosing Agents in the Treatment of Varicose Veins."

Dr. Dean Lewis, Baltimore—"Muscle, Nerve and Blood Vessel Injuries of the Extremities."

Dr. Carl A. Hedblom, Chicago—"The Diagnosis and Treatment of Tumors of the Thorax."

Dr. W. Wayne Babcock, Philadelphia—"The Vaginal Approach to the Peritoneum."

Dr. W. R. Houston, Augusta—Subject to be announced later.

Dr. Curtice Rosser, Dallas—"Problems Confronting the Proctologist."

Dr. Irvin Abell, Louisville—"Tumors of the Breast."

Dr. Robert Wilson, Charleston—"The Fundamentals of Surgery—a Medical Viewpoint."

Dr. Cecil Rigby, Spartanburg—Subject to be announced later.

Dr. Russell O. Lyday, Greensboro—"Surgical Progress from a Physiological Standpoint."

Drs. Vilray P. Blair and James Barrett Brown, St. Louis—"Cancer of the Mouth."

Clinics will be held also. The complete program will be mailed out about February 15, 1933.

Dr. Luther Holloway and Dr. Shaler Richardson of Jacksonville visited the Volusia County Medical Society on December 13th.

* * *

Dr. Robert B. Harkness of Lake City was awarded the Legion distinguished service medal for 1932 at a public ceremony held in Olustee park on Armistice day. The presentation was made by Dr. T. H. Bates, past post commander. The award was given to Dr. Harkness "for his outstanding work in community service as represented by his founding and establishment of Lake Shore Hospital, an institution that has filled a very important need in the community life of Lake City, Columbia County and north Florida." This is the second annual award made by the Columbia County Post No. 57, American Legion Department of Florida.

* * *

Dr. and Mrs. H. M. Beardall of Orlando spent several days in December with a party of hunters in the woods of the Tosohatchee game preserve near Ft. Christmas. They reported quantities of quail and some turkeys were to be found.

* * *

The Shrine Club of St. Petersburg recently honored Dr. J. A. Strickland at a public dinner dance at the club house. Dr. Strickland is the newly elected president of the Club.

* * *

Dr. B. F. Butler of Hollywood recently addressed the West Palm Beach Rotary Club.

* * *

Dr. and Mrs. Thos. B. Echard of St. Petersburg had as their holiday guests their sons, Thomas B. Echard of Pittsburgh and Richard W. Echard, a student at the University of Virginia.

* * *

The Committee on Scientific Work of the Association will meet on January 29th at Ocala to select the papers which will comprise the program of the next annual meeting of the Association. Dr. L. M. Anderson, Lake City, is chairman of the committee, with Drs. Leland Carlton, Tampa, and Edward Jelks, Jacksonville, serving as members.

At the same date and place, there will be a meeting of a special committee recently appointed to study the relations between the Florida Medical Association and the State Board of Health. Representatives from the State Board of Health will also attend.

The 1933 annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 9 to 13. The Stevens Hotel will be headquarters for the meeting.

* * *

At a recent meeting of the Peace River Federation of Women's Clubs, Dr. A. L. Stebbins of Punta Gorda spoke on "The Physical Side of the Home."

* * *

Announcement has been made that the American College of Physicians will hold its Seventeenth Annual Clinical Session at Montreal, with headquarters at the Windsor Hotel, February 6-10, 1933. The executive secretary, 133-135 S. 36th St., Philadelphia, Pa., is in charge of the general business arrangements, and may be addressed concerning any features of the forthcoming Session, including copies of the program.

* * *

The Southern Surgical Association held a very successful meeting at Miami, December 13-15. This Association has a limited membership of 200. Forty papers were read and discussed during the scientific sessions. Dr. J. Knox Simpson of Jacksonville was among those honored by a place on the program. The following officers were elected: Dr. Vilray P. Blair, St. Louis, president; Drs. E. H. Adkins, Miami Beach, and Owen W. Barnett, Louisville, Ky., vice-presidents; Dr. R. L. Payne, Norfolk, Va., secretary, and Dr. Lloyd Noland, Fairfield, Ala., treasurer. Hot Springs, Va., was chosen for the next convention.

* * *

The Staff of the Pensacola Hospital held a business meeting on December 13th and elected the following officers:

President—C. W. D'Alemberte.

Vice-President—A. M. Ames.

Secretary—J. D. Bell.

Drs. J. M. Hoffman and J. J. McGuire were made additional members of the Executive Committee.

* * *

Dr. Luther W. Holloway and Dr. Shaler Richardson of Jacksonville recently addressed the Woman's Club of DeLand. The subject of Dr. Holloway's talk was "Care and Feeding of Infants," and of Dr. Richardson's, "Care of School Children's Eyes."

* * *

Dr. W. E. Morgan, formerly of Tarpon Springs, has moved to Chicago to resume practice.

Dr. Howard Bucknell, formerly of Clearwater, has moved to Atlanta and resumed the practice of pediatrics.

* * *

Dr. Alvin L. Mills of St. Petersburg was a recent visitor in Jacksonville to attend the funeral of his father, Mr. J. H. Mills, who had been a resident of that city for the past thirty-five years. While in Jacksonville, Dr. Mills conferred with the officers and legal advisors of the Association on society affairs.

* * *

At the recent examination of the State Board of Medical Examiners held in Jacksonville, on November 14 and 15, there were thirty-six applicants. Three were refused the privilege of taking the examination, one having received his degree from a low grade medical college, the other two for their failure to file citizenship papers.

Dr. W. M. Rowlett, Secretary of the Board, reports that of the thirty-three applicants who took the examination, twenty-nine were successful and have been issued licenses. They are as follows:

Julius Alexander	Miami, Florida
W. P. Baugh	Decatur, Alabama
John L. Bennett	Augusta, Georgia
Sam Bergman	Tampa, Florida
John Joseph Bourke	Tampa, Florida
J. Paul Chapin	Mannville, Florida
Moses Austin Chardkoff	Tampa, Florida
Raul Roque de Escobar	Tampa, Florida
Don Carlos Eskew	Chattanooga, Tennessee
Allen P. Gurganious	Jacksonville, Florida
Osmah Elias Harrell	Augusta, Georgia
S. C. Harvard	Atlanta, Georgia
Laura Mary Hobbs	Miami, Florida
Allen R. Howard	Miami, Florida
R. Spencer Howell	Miami, Florida
William H. Izlar	Philadelphia, Pennsylvania
A. L. Matthews, Jr.	Jacksonville, Florida
J. Zeb McDaniel	Augusta, Georgia
Margaret Harper McKee	Tampa, Florida
Thomas Earl Moore	Miami, Florida
Estella G. Norman	Battle Creek, Michigan
Wendell Hunt Peacock	Wauchula, Florida
J. H. Pinholster	Jacksonville, Florida
Edwin P. Preston	Miami Beach, Florida
James Curtis Rinaman	New Orleans, Louisiana
W. C. Roberts	Panama City, Florida
R. H. Segrest	Bonifay, Florida
John Raymond Smith	Miami, Florida
Byrne E. Taylor	Orlando, Florida

* * *

Dr. Edward Jelks, Jacksonville, has been reappointed the member of the Council of the Southern Medical Association from Florida for a regular council term of three years, the appointment having been announced recently by the president, Dr. Irvin Abell, Louisville, Kentucky.

At the recent meeting of the Southern Surgical Association, which was held in Miami, Dr. Edward Jelks, Jacksonville, was elected a Fellow of the Association.

* * *

Dr. Frederick Oetjen of Jacksonville announces the removal of his office from the St. James Building to the Smith Building, 211 E. Forsyth St.

* * *

The American Association for the Study of Goiter, for the fourth time, offers three hundred ($300.00) dollars as a first award, and two honorable mentions for the best three essays based upon original research work on any phase of goiter presented at its annual meeting in Memphis, Tenn., May 15th, 16th, and 17th, 1933. It is hoped this will stimulate valuable research work, especially in regard to the basic cause of goiter.

Competing manuscripts must be in English and submitted to the Corresponding Secretary, J. R. Yung, M.D., 670 Cherry St., Terra Haute, Indiana, not later than April 1, 1933. Manuscripts arriving after this date will be held for the next year or returned at the author's request.

The First Award of the Hamilton, Ontario, Canada, 1932, meeting was given Donald McEachern, M.D., Johns Hopkins Hospital, Baltimore, Md., "A Consideration of the Mechanism of Hyperthyroidism Based upon its Effect upon Cardiac and Skeletal Muscle."

Honorable mention were awarded A. B. Gutman, M.D., Presbyterian Hospital, New York City, "The Effect of Administration of Iodine on the Total Iodine, Inorganic Iodine and Thyroxine Content of the Pathological Thyroid Gland." Lieut. Col. H. Scott, M.R.C.P., I.M.S., Dean Faculty of Medicine, Lucknow University, Lucknow, India, "The Distribution and Cause of Endemic Goitre in the United Provinces."

* * *

Dr. Frederick J. Waas of Jacksonville made an aeroplane trip to Sebring, November 20th, having been called in consultation.

* * *

Dr. H. E. Palmer of Tallahassee has resigned his presidency of the Leon County Taxpayers' League, it was recently announced. Dr. Palmer gave as the reason for his action the fact that he cannot devote the necessary time to the office to which he was elected in November.

COMPONENT COUNTY SOCIETIES

ALACHUA COUNTY MEDICAL SOCIETY

At the December meeting of the Alachua County Medical Society, held at the luncheon hour at Hotel Thomas, the following officers were elected for the ensuing year:

President—J. L. Summerlin, Gainesville.
First Vice-Pres.—J. Maxey Dell, Gainesville.
Second Vice-Pres.—R. E. Summitt, Gainesville.
Sec'y-Treas.—J. Maxey Dell, Jr., Gainesville.

A feature of the scientific program was a paper on "Rabies" read by Dr. R. E. Summitt. In the discussion that followed the reading of the paper, action was taken, authorizing the secretary to represent the society before the City Commission of Gainesville, recommending that the law requiring the vaccination of all dogs be enforced in the interest of the general public.

A brief outline of the past year's activities was given by the retiring secretary, Dr. E. H. Andrews.

BREVARD COUNTY MEDICAL SOCIETY

At a recent meeting of the Brevard County Medical Society, the following officers were elected to serve for 1933:

President—W. J. Creel, Eau Gallie.
Vice-President—Robt. Schlernitzauer, Cocoa.
Sec'y-Treas.—K. I. Hicks, Melbourne.

DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held its annual election of officers on the evening of December 2nd. The following doctors have been selected for the ensuing year:

President—Gerard Raap, Miami.
Vice-President—George N. MacDonell, Miami.
Secretary—Robert T. Spicer, Miami.
Treasurer—H. A. Barge, Miami.

Dr. Eugene B. Maxwell was elected to the Board of Censors, which includes Dr. R. M. Harris and Dr. Homer Pearson.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society met at the Jacaranda Hotel, Avon Park, at 8 p. m., December 13th. A communication from Dr. Gerry Holden and Dr. Shaler Richardson, president and secretary of the State Association was read, suggesting that a protest be made to the Veterans' Legislation Committee

at Washington, relative to the furnishing of free medical services to veterans for lesions not dependent on war conditions. After considerable discussion, the secretary was instructed to write such a letter. The following officers were elected to serve for 1933:

President—J. A. Simmons, Arcadia.
Vice-President—G. F. Highsmith, Arcadia.
Sec'y-Treas.—L. W. Martin, Sebring.
Censor—A. A. Poucher, Wauchula.
Delegate to State Meeting—H. V. Weems, Sebring.
Alternate Delegate—I. W. Chandler, Avon Park.

It was voted that dues remain $13.00 for the ensuing year.

After the business meeting, Dr. J. P. Tomlinson, a guest of the society, presented a paper on "Emphysema of Neck and Chest of a Woman in Normal Labor."

DUVAL COUNTY MEDICAL SOCIETY

At the annual meeting of the Duval County Medical Society, held at the Mayflower Hotel, Jacksonville, on the evening of December 6th, the following officers were elected:

President—J. Knox Simpson.
Vice-President—Kenneth Morris.
Secretary—F. L. Fort.
Treasurer—E. C. Swift.

Dr. Clayton Royce was elected to the Board of Governors. The following were elected as delegates to the next convention of the Florida Medical Association: Drs. W. M. Shaw, S. E. Driskell, F. J. Waas, Ralph N. Greene, Edward Jelks, J. K. Simpson, John E. Boyd and Robert McIver. Drs. F. L. Fort, Kenneth Morris, S. R. Norris and Herrman Harris were named alternate delegates.

The Duval County Medical Society has taken steps toward the inauguration of an extensive educational campaign by which it hopes to reduce materially the number of automobile fatalities in the community. Through a committee composed of Dr. Ralph N. Greene, chairman, and Drs. Ernest B. Milam, Edward Jelks, F. L. Fort and Theodore G. Croft, the society has enlisted the support and active cooperation of city officials.

The program of education will be presented to the public through the press, over the radio, by motion pictures and in messages to the various civic organizations.

"Emphasis in this campaign," the mayor told the conferees, "should be placed upon teaching the people to observe the law rather than stressing the enforcement of the law."

That does not mean, however, that the traffic laws are not to be enforced, Judge Anderson assured the doctors. He asserted, and the committee members agreed with him, that an important phase of the campaign rests upon the enforcement of the law and the meting out of punishment to law violators.

Carefulness in driving will be emphasized in the society's messages to the public. Its members will point out that careless and indifferent driving are responsible for a huge percentage of automobile accidents and motor fatalities.

The Medical Society's interest in the campaign and its decision to sponsor a safety drive to make Jacksonville and Duval County a safer place in which to drive was summed up by Dr. Greene as follows:

"The medical profession is clothed with the responsibility of ministering to a group of automobile accident victims, 94 per cent of whom are recipients of a beneficence along with an ever-increasing necessity for the extension of charity professional service in other fields of medical and surgical endeavor.

"Physicians, being exponents of preventive measures for human protection, recognize the existence of many preventable elements in automobile accidents and fatalities."

ESCAMBIA COUNTY MEDICAL SOCIETY

The Escambia County Medical Society met on December 13th and elected the following officers:

President—C. J. Heinberg.
Vice-President—Alvyn White.
Sec'y-Treas.—J. M. Hoffman.
Censors—C. C. Webb, H. L. Bryans and A. R. Haisfield.

Scientific papers were presented by Drs. Alvyn White and J. H. Fellows. Naval hospital doctors were present at the banquet as guests of the society.

HILLSBORO COUNTY MEDICAL SOCIETY

At a recent meeting of the Hillsboro County Medical Society, the following officers were elected for the ensuing year:

President—E. H. McRae, Tampa.
Vice-President—Edward Smoak, Tampa.
Sec'y-Treas.—C. W. Bartlett, Tampa.

Drs. W. P. Adamson, C. A. Andrews, J. R. Boling, H. Mason Smith and R. A. Ely were elected delegates to the next convention of the state association.

MARION COUNTY MEDICAL SOCIETY

The Marion County Medical Society held its regular monthly meeting at the Marion Hotel, Ocala, at 12:30 p. m., December 15th. An interesting paper on "Myocarditis" was read by Dr. E. G. Lindner. The following officers were elected for 1933:

President—J. L. Strange, McIntosh.
Vice-President—A. H. Freeman, Ocala.
Sec'y-Treas.—W. B. Jordan, Ocala.

ORANGE COUNTY MEDICAL SOCIETY

The regular November meeting of the Orange County Medical Society was held at 8:30 p.m., November 16th, in the lounge of the Orange General Hospital, with Vice-President Dr. Hewitt Johnston in the chair. The evening was spent in the discussion of various phases of approaching state medicine, especially the influence of health associations and hospital insurance activities, as associated with industrial medicine.

During the discussion it was brought out that in Orlando, there has been organized a Florida Health Service Association, which will for the payment of one dollar per month give medical attention, hospitalization, operations, laboratory work, etc. For obstetrical patients one-half the regular delivery charge is made. This association sends its policyholders to the Florida Sanitarium for treatment. It is said no contract exists between the health association and the Florida Sanitarium, but the same man is secretary of both. As the physicians of the Sanitarium are under contract, that is, being paid a monthly salary for their work, it was felt that this was violating both the letter and the spirit of one of the By-Laws of the Orange County Medical Society, which was adopted some months ago: "Any member who may advertise in a lay Journal or broadcast, without the subject matter being submitted before and approved by the Board of Censors of the Orange County Medical Society, shall be subject to suspension from the Society. This also shall apply to any member who speaks for any special method or methods of treatment advocated by any institution with which he may be connected; or who shall employ any unethical method for gaining the attention of the public for the purpose of obtaining patients."

Based on this infringement of the By-Laws, charges were instituted against the Florida Sanitarium physicians so employed and the Board of Censors were instructed to make a report at the December meeting.

The annual meeting of Orange County Medical Society was held in the Orange General Hospital lounge, Wednesday evening, December 20th, with President G. S. Osincup in the chair. Col. Geo. C. Johnston gave a very interesting talk on the report of the Committee on the Cost of Medical Care and his very illuminating discussion brought out that whereas the report of the minority, in some small country communities might be accepted and put into operation; for large communities where there are two or more institutions for care the plan would be a failure; the report of the majority is, however, visionary and communistic; at present the needs of the sick are probably best handled by the method in effect today possibly with some modification by which communities formulate some plan to take care of the indigent in their own section.

An animated discussion took place regarding the relationship of the doctors and the State Board of Health immunization and indigent work. The consensus of opinion seemed to be that the State Board of Health and the practitioner are so interlocking that the collapse of either activity would spell catastrophe to civilization.

Following the report of the treasurer showing a balance of $330.00 in the treasury, beside a frozen asset of something like $500.00 in a closed bank, a motion was made and carried reducing the dues from the present $15.00 rate to $12.00. The County Society for a number of years has been setting aside $3.00 per member per year to go into a fund to entertain the State Association as frequently as possible, but under the able management of our present business head, this added assessment is unnecessary.

A committee composed of the Board of Censors, *i. e.*, Doctors W. H. Spiers, Meredith Mallory and J. H. Chiles, in collaboration with Drs. C. D. Christ, Spencer Folsom and G. H. Edwards, was appointed to confer with the superintendents and directors of the Florida Sanitarium and the Orange General Hospital regarding the possible

adoption of certain features in the minority report of the Committee on the Cost of Medical Care.

The report of the Board of Censors on the preferred charges against several of our members for unethical advertising was read and the trial was set for January 4th.

The following officers were elected for the ensuing year:

President—Dr. Hewitt Johnston.
Vice-President—Dr. J. R. Chappell.
Secretary—Dr. Louis Orr.
Treasurer—Dr. Chas. Collins.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Members of the Pasco-Hernando-Citrus County Medical Society were guests of Dr. Leland H. Dame at a meeting held the latter part of November. Dr. Dame's guests enjoyed a dinner at the Orange Hotel, Inverness. Those in attendance were: Drs. L. T. Furlow and Geo. R. Creekmore of Brooksville; Dr. T. F. Jackson, Dade City; Dr. David A. Mills, Zephyrhills; Drs. P. J. Hudson and W. B. Moon, Crystal River, and Drs. George Dame and Leland Dame of Inverness.

POLK COUNTY MEDICAL SOCIETY

The election of officers of the Polk County Medical Society was held at a dinner meeting at the Morrell Memorial Hospital, December 14th. Members of the Lakeland Dentists' Association were guests of the society. The following officers were elected:

President—W. T. Simpson, Winter Haven.
Vice-President—H. B. Cordes, Frostproof.
Sec'y-Treas.—J. R. Boulware, Jr., Lakeland.

Miss Lillian Kiels of Hollywood gave an interesting talk on "The Correction of Cleft-Palate Speech." She was introduced by Dr. J. P. Getzen.

The next meeting of the society will be held the second Wednesday in February.

PINELLAS COUNTY MEDICAL SOCIETY

Drs. G. H. Edwards and Meredeth Mallory of Orlando were guests of the Pinellas County Medical Society at its regular meeting, January 6th.



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Dr. Edwards delivered a most interesting and instructive paper on "Immediate Repair of the Peritoneum Following Labor." Dr. Mallory's paper was entitled "Agranulocytosis, With Case Report." Both papers were well received by the Society.

SARASOTA COUNTY MEDICAL SOCIETY

Dr. Jack Halton, retiring president of the Sarasota County Medical Society, entertained the society at a meeting held December 21st. The meeting took place in Dr. Halton's home. The annual election of officers resulted as follows:

President—O. H. Cribbins, Sarasota.
Vice-President—T. W. Taylor, Sarasota.
Sec'y-Treas.—J. E. Harris, Sarasota.

At the conclusion of the business meeting, refreshments were served.

SEMINOLE COUNTY MEDICAL SOCIETY

The December meeting of the Seminole County Medical Society took the form of an oyster supper held at the Fernald-Laughton Memorial Hospital. At the business session, the following officers were elected for 1933:

President—J. N. Tolar, Sanford.
Vice-President—A. W. Knox, Sanford.
Sec'y-Treas.—J. T. Denton, Sanford.

Dr. W. T. Langley was chosen delegate to the next annual meeting of the state association with Dr. G. S. Se'man named as alternate.

Dr. J. Ralston Wells of Daytona Beach spoke on "Drugs Best Used in Pre-Operative and Post-Operative Cases."

VOLUSIA COUNTY MEDICAL SOCIETY

The Volusia County Medical Society held its annual meeting at DeLand December 13th. A 7 o'clock dinner was enjoyed by the society and its auxiliary at the Hotel College Arms. Following the dinner, the business session convened, during which the following officers were elected for the ensuing year:

President—L. B. Bouchelle, New Smyrna.
Vice-President—Roy Howe, Daytona Beach.
Sec'y-Treas.—J. H. Rutter, Daytona Beach.

Dr. Shaler Richardson, secretary of the Florida Medical Association, and Dr. Luther W. Holloway, both of Jacksonville, were guests of the society during the evening.



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The following is from the pen of Mrs. James F. Percy of Los Angeles, California, who, being first vice-president, succeeded Mrs. Freeman as president of the Woman's Auxiliary to the American Medical Association:

"Mrs. Walter Jackson Freeman, 1868-1932.

"With feelings of deepest regret, the Woman's Auxiliary must record the passing of its National President, Mrs. Walter Jackson Freeman, at Philadelphia on October 27, 1932.

"It has been a tribute to her that for so many years deep responsibilities have been entrusted to her vision, ability and wisdom, until finally the highest honors in the power of the Auxiliary members to give, had been bestowed upon her.

"Life, in its strange and mysterious way of deciding for us when the day's work is done brought to her the glad tidings of peace and rest, leaving to other hands the task of picking up the ends left loose by her trip to the middle western states and her fatal illness which immediately followed. To that end, we shall, I know, all dedicate ourselves that the close of this fiscal year shall find as far as is in our power, the ideals and structure which she endeavored to build, consummated.

"Through sorrow our hearts will be newly welded together. Our efforts will be strengthened with a finer unity of purpose to which each, we ask, shall pledge herself in memory of the one who is gone.

"To my tasks, as her successor, I willingly devote myself and my best efforts, knowing the spirit of the Auxiliary and that the same loyal support and cooperation of the past will be vouchsafed to those officers whom she left to carry on."



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Some of the high lights of the state reports given at the recent meeting of the Auxiliary to the Southern Medical Association, as furnished by Mrs. Eugene Peek of Ocala, who represented Florida, are—Alabama reported an increase in membership of 88 per cent.

Arkansas reported five new Auxiliaries, Mississippi and Oklahoma each had two new Auxiliaries, Georgia and Tennessee are endeavoring to have Auxiliaries in every county.

Practically all the states stressed Hygeia. Many of them did creditable work for the needy, for crippled children and for tubercular patients. Virginia raised $1,600.00 for the last named cause. Many health programs were given in other clubs as well as over the radio.

* * *

PINELLAS COUNTY AUXILIARY

An interesting and comprehensive discussion of county health and sanitation work was presented to the auxiliary to the Pinellas County Medical society by Dr. Wyman W. Harden at its luncheon meeting at the Shrine club.

Dr. Harden reviewed the work as conducted under the existing system and told of the desirability of reorganizing such work under the county health unit plan.

Following reports made by committee chairmen, the members of the auxiliary voted a $5 contribution to The Times Empty Stocking Fund.

Guests of the members were Mrs. Soule of Buffalo, N. Y., Mrs. Anderson of St. Petersburg, Mrs. J. T. Hurd of Galeton, Pa., and Mrs. H. D. Laye of Asheville, N. C.

Members present were Mesdames T. B. Echard, O. O. Feaster, W. W. Harden, C. E. Hebard, Prescott LeBreton, F. H. Langley, George Miller, R. K. O'Brien, W. C. McConnell, E. C. MacCordy, Glenn Post, J. B. Quicksall, W. E. Quicksall, A. P. Roope, F. W. Roush, J. A. Strickland, M. H. Stuart, Carl Williams and LeRoy Wylie.

* * *

POLK COUNTY AUXILIARY

The fifth meeting of the Auxiliary to the Polk County Medical Society was held in Lakeland at Murdock's Cafe, Wednesday, December 14th, at 7 o'clock.

After dinner, the members went to the home of Mrs. John F. Wilson, where the third lesson from the Study Course on Medical and Health Laws, "Vital Statistics," was discussed by the Publicity Chairman, Mrs. Walter A. Weed.

Mrs. J. D. Griffin and Mrs. R. L. Cline, of Lakeland, were appointed to make arrangements for the meeting place in Lakeland the second Wednesday in February. Mrs. J. R. Boulware, Jr., Mrs. G. C. Overstreet, and Mrs. Walter A. Weed, Lakeland, were appointed on the program committee for the next meeting.

Mrs. Peter Besenbruch, Davenport, and Mrs. T. W. Causey, Lakeland, were new members added to the roll.

The meeting then adjourned, and bridge was enjoyed till the doctor husbands came from their meeting at the Morrell Memorial Hospital.

Members present were: Mrs. E. R. McMurray and Mrs. C. H. Murphy, Bartow; Mrs. V. H. Ragsdale, Pierce; Mrs. Peter Besenbruch, Davenport; and Mrs. J. R. Boulware, Jr., Mrs. T. W. Causey, Mrs. R. L. Cline, Mrs. J. D. Griffin, Mrs. J. G. Lester, Mrs. G. C. Overstreet, Mrs. S. F. Smith, Mrs. W. L. Tillis, Mrs. J. W. Vaughn, Mrs. Herman Watson, Mrs. J. F. Wilson, and Mrs. Walter A. Weed, Lakeland.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	J. Maxey Dell, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	
Bay	W. J. Lee, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	
Hillsboro	C. W. Bartlett, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel Bradenton	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	Louis Orr, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	V. M. Johnson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	
Polk	J. R. Boulware, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital Sanford		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	

NOTE—Secretaries: Please submit information to complete the above schedule.

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VOLUME XIX
NO. 8

Jacksonville, Florida, February, 1933

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THE N.Y. ACADEMY OF MEDICINE
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NEXT SESSIONS Florida Medical Association, Hollywood, May 1-3, 1933
American Medical Association, Milwaukee, June 12-16, 1933.

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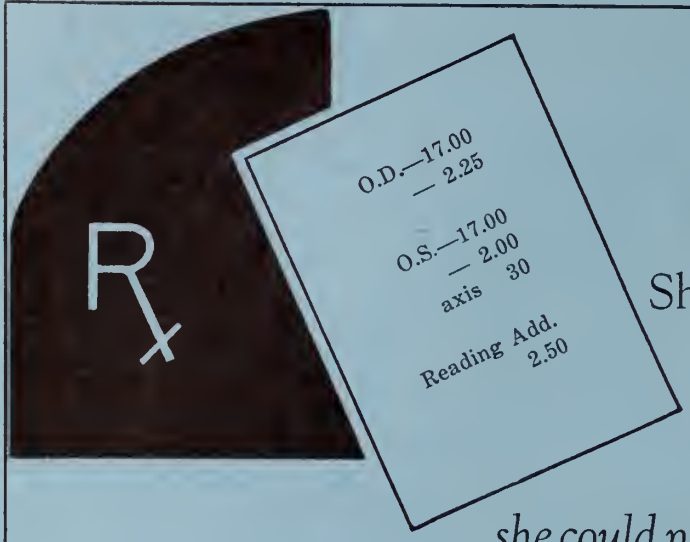
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XIX Jacksonville, Florida, February, 1933 Number 8

PEPTIC ULCER*

J. Knox Simpson, M.D., F.A.C.S.,
Jacksonville.

There are certain known facts and certain rather speculative theories relative to the cause of peptic ulcer which, when taken together, form a plausible background upon which to build up an explanation of the widespread prevalence of this disease. A review of the conditions which are probably at work in the production of an acute ulcer and its conversion into the well-known chronic type will serve to indicate the principles upon which our treatment of this condition should be based.

The factors which seem to be necessarily at work in the business end of the stomach if we are to have an ulcer form and become chronic are as follows:

1. Irritability of the pyloric region, giving rise to hyperactivity of the expulsive forces of the ampulla and to spasm of the pyloric muscle.

2. Hypersecretion of acid, and accumulation of hyperacid contents, giving rise to increased chemical irritation.

3. Increased impact of the rough elements of the diet (from increased peristaltic force) against both the lesser curvature of the stomach, the more fixed portion, and the first portion of the duodenum, the ulcer area.

What serves to set in motion these factors, which when once under way are interdependent and involved in a vicious circle of pylorospasm, increased peristalsis, increased secretion, increased acidity, increased chemical and mechanical irritation, and back to pylorospasm again?

First, we know that ulcer practically always occurs in the most active period of life, most often in males, and in those males who are in the midst of great mental activity and stress. It rarely occurs in Morons, or in the lower order of man or in animals. Dr. Crile thinks that the ulcer victims fail to rationalize their mental stimuli from without, and that these stimuli are transferred by the autonomic nervous system to the thyroid and adrenal glands. These in turn step up all metabolic processes, giving rise in the stomach to increased secretion, increased peristalsis, increased acid production, increased irritability of individual cells, and increased electrolysis at the neutral point between the acid contents of the stomach and the alkaline tissues of its wall, and at the neutralizing point where the acid stomach contents meets the alkali of the duodenum. His observations are borne out clinically by the presence of hyperacidity and hyperperistalsis of the stomach in patients with hyperthyroidism and the reverse in those with myxedema. Upon the basis of the above pretty theory it is possible that certain cures of ulcer by Christian Science are tracable to mental equanimity, resulting in cessation of thyroid stimulus, and thus in gastric stimulus with its increased acid and activity, constituting as it were a mental Sippey treatment.

Infections of a focal character can undoubtedly exhibit a selective action for the mucosa in the ulcer areas, and produce a duodenitis and acute ulcer, as demonstrated many times by Rosenow. This in turn may, it seems, inaugurate the vicious circle which once under way carries the process on to chronic ulcer formation.

Extragastric lesions such as appendicitis or cholecystitis at times produce pylorospasm which, it is true, may begin as a protective measure, an effort to automatically shut off the digestive stream at its source in order to protect regions of trouble below, but which may project itself over from the field of physiologic response to that of pathologic physiology. This may, it would seem reasonable to believe, give rise to chronic spasm of the pylorus with its train of necessarily increased peristalsis of the stomach, increased acidity, increased force of propulsion, providing the necessary increased chemical and mechanical trauma for the production of an ulcer. Judd has proven the entity of pre-ulcer duodenitis by pathologic section, and Deaver advocated and practiced subperitoneal resection of the anterior half of the pyloric ring as a prophylactic measure in these pre-ulcer syndromes.

Mann has been repeatedly able to produce

*Read before the Duval County Medical Society, Jacksonville, November, 1932.

chronic jejunal ulcers in animals by shunting the alkaline duodenal contents into the ileum and emptying the acid gastric contents into the jejunum, devoid of its alkaline content. The ulcers form at the point where the acid gastric contents strike the mucosa of the jejunum which is unprepared for fluid of acid reaction. They occur about one month after operation, and have all the characteristics of chronic ulcers in the human being. This tends to add experimental proof to the assumption that chemical and mechanical trauma have an important part in the formation of ulcer of the stomach and duodenum, and of jejunal ulcer following gastroenterostomy.

We turn now to the diagnosis of peptic ulcer. This is not difficult if one will take the time and patience to thoroughly investigate each case of chronic dyspepsia and not prescribe some pet digestive medicine without first making a complete study of the case. It is not a rare disease by any means. Autopsies of thousands of cases show an incidence of peptic ulcer, either active or healed, in about 10% of the cases. Lahey, in a recent paper on this subject, states that one in 23 patients entering his clinic on all services during last year, proved to have peptic ulcer. I know of no disease which comes so clearly labeled in the patient's story of his illness, the crux of which is a distinct periodicity of symptoms and a very definite relation to the intake of food. The distress is one of gnawing and burning in the epigastrium, coincident with and caused by active secretion of acid and muscular spasm, which is definitely relieved by neutralization of the acidity and relaxation of the spasm. This has usually been found out by the patient who states that he takes soda or food and obtains relief. The periodicity of the symptoms and the tendency for them to recur is probably due to a constant tendency of the ulcer to heal, and a recurring trauma to the granulating base or to the thin primary epithelial covering before it has had time to proliferate to the normal thickness.

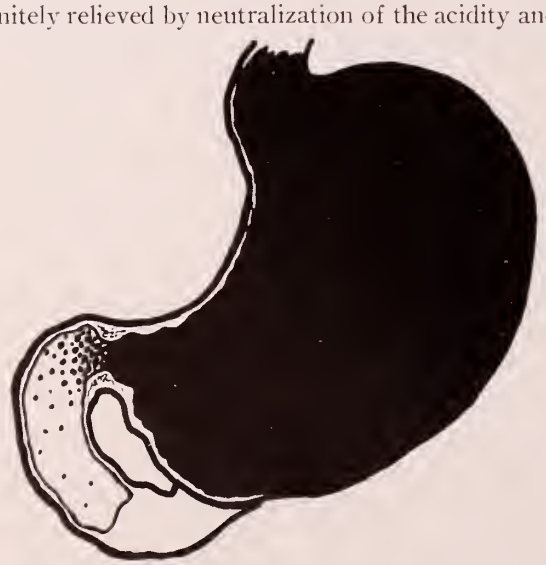


Fig. 1. Schematic representation of normal neutralization of acid chyme as it passes through a normal pylorus. Legend: Black = acid; White = alkali; Shaded = admixture of acid and alkali.

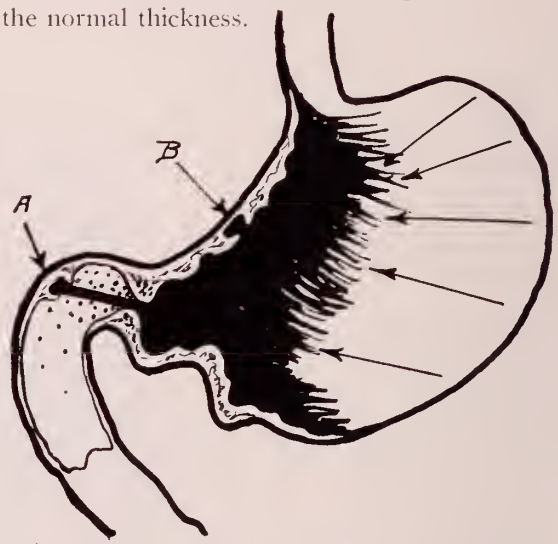


Fig. 2. Schematic drawing showing (a) crater of duodenal ulcer at the site where acid chyme strikes the duodenal wall in a small forceful stream due to spasm of pylorus, hypertrophy of stomach wall and hyperperistalsis; (b) crater of gastric ulcer on lesser curvature. This is the more fixed portion of the stomach and bears the brunt of the forceful propulsion of gastric contents against it, the arrows indicating the lines of force. It is therefore subjected to both mechanical and chemical trauma. Legend: Black = acid; White = alkali; Shaded = admixture of acid and alkali.

When out of the parade of chronic dyspeptics passing through the hands of the physician he has picked the ones with probable ulcer, which only requires a careful history to do, he should subject these to the further study of gastric contents analysis, search of the stools for occult blood, and X-ray study with the opaque meal. It is highly essential that the diagnosis be positively made if an ulcer is present, because treatment, to be effective, whether medical or surgical, is going to require a great deal of time and patience on the part of both physician and patient in order to effect a lasting cure.

The principles underlying the treatment of peptic ulcer, whether it be medical or surgical, very naturally involve an attack upon the forces at work in its production. This means:

1. Removal of foci of infection which may harbor organisms with a specific selective action on the gastric and duodenal mucosa.

2. Neutralization of the excessive acidity of the stomach contents.

3. Relief of the spasm of the pylorus and of the hyperperistalsis of the stomach.

4. Withdrawal of the traumatizing elements of the diet.

Let me say at the very outset that I feel that the accomplishment of the above objectives requires very earnest thought on the part of both physician and surgeon, and usually their joint cooperation, in order to decide in each individual case the best course to pursue in order to affect a cure with the least danger, loss of time and loss of money to the patient. I think the day is past when physicians or surgeons can blindly advocate their particular line of attack on this problem as either the only one or the best one for all cases.

Taking up the objectives of treatment singly, and viewing in a judicial frame of mind, the methods of attack offered in each objective by the medical and by the surgical treatment, we will see that the same general principles guide them both.

1. The removal of foci of infection belongs usually to the surgical specialties, and should be done in all cases, whether under medical or surgical treatment. The removal of intra-abdominal lesions such as chronically inflamed gall-bladders or appendices of course comes under the surgical management, and in a certain considerable proportion of cases provides one reason for the adoption of surgical in preference to medical treatment.



Fig. 3. Showing, schematically, the changed physiology at the pylorus following a resection of a duodenal ulcer and a pyloric reconstruction after the plan of Judd. Legend: Black = acid; White = alkali; Shaded = admixture of acid and alkali.

2. Relief of spasm of the pylorus and hyperperistalsis, and neutralization of the excessive acidity can be grouped together in treatment. It is accomplished in the medical regimen by rest in bed, the hourly administration of large enough doses of alkalis to neutralize the acid, and of a milk and cream diet at frequent intervals. This gives a very bland mixture in the stomach at all times, avoiding all stimuli of a chemical or a mechanical nature, and therefore putting the ulcer area at rest and allowing healing to take place. This will undoubtedly occur in a large majority of the acute ulcers and in a considerable number of the chronic ones.



Fig. 4. Schematic representation of changed physiology following gastrojejunostomy. (A) Crater of duodenal ulcer. Note spasm of pylorus and admixture of stomach and jejunal contents at gastrojejunostomy opening. Legend: Black = acid; White = alkali; Shaded = admixture of acid and alkali.

Surgery attacks the same problems in a different manner, supplemented by the use of some of the same means. In the simple small ulcers of the duodenum this is probably best accomplished by resection of the ulcer area, destruction of the contact ulcer, if there be one on the posterior surface of the duodenum, resection of the anterior half of the pyloric muscle, and closure of the wound as a pyloroplasty. This immediately accomplishes three things: first, the removal of a calloused ulcer which is slow to heal, and with it the possibility of perforation and hemorrhage; second, the cessation of pylorospasm, and the institution of better drainage to the stomach, because the pyloric ring is cut, and can no longer close the pyloric opening; third, alkalinization of the acid gastric contents as it is secreted, by a reflux of

alkaline duodenal contents into the stomach through the open pylorus.

In the larger ulcers with partial obstruction and fixation of the duodenum, these same objectives are accomplished by a gastrojejunostomy, which immediately affords better drainage to the stomach, thereby lessening the spasm of the pylorus.

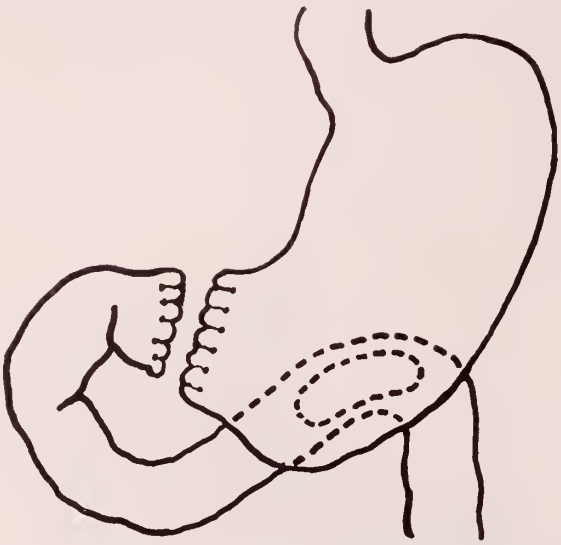


Fig. 5. Exclusion of ulcer area in duodenum by section above pylorus, closure of ends of stomach at section and gastrojejunostomy. This is a useful procedure in certain cases of large, thickened duodenal ulcers.

Alkalanization of the stomach contents is accomplished by a reflux through the gastroenterostomy opening.

In those large, fixed, and recurrently bleeding ulcers it is sometimes advisable to section the stomach just proximal to the pylorus, close the ends and add a gastroenterostomy. This puts the ulcer area at complete rest, allowing no food to pass over it, and yet is not a procedure of the magnitude of pyloric resection.

Resection of the pyloric end of the stomach, taking away the acid-manufacturing area, and reestablishing the gastrointestinal continuity, as advocated by Finisterer, Haberer, and some of the New York surgeons, for duodenal ulcer, seems to most surgeons of wide experience in this country to be too radical a procedure for this type of lesion. Statistics would indicate that the mortality of this operation, even in very experienced hands, is about as high as the rate of recurrence of ulcer symptoms in the less radical procedures. The avoidance of this recurrence constitutes the main objective for which the more radical operation is advocated.

3. Withdrawal of the traumatizing elements of the diet is the same in both medical and surgical treatment, and consists of removal of chaff, cellulose strings, and condiments, plus the provision of some sort of bland food in the stomach at all times. The post-operative management of the surgical cases is quite the same in this regard as the medical management, except for the length of time it must be kept up.

Now, then, given a case of peptic ulcer, where the diagnosis is positive, and has been confirmed as certainly as can be done without intra-abdominal inspection, what are we to advise the patient, and what shall guide us in this advice? This is a difficult question to answer in many cases, but there are guides which we may use, and which have been arrived at by the joint experiences of many careful observers in handling these cases. A process of sorting the cases into medical and surgical groups can be readily done for a part of the number; the remainder become difficult.

First, those which go immediately into the surgical group are:

Acute perforations; repeated and severe hemorrhages; ulcers which have not responded to careful medical treatment, or show evidences of recurrence in spite of good medical treatment; pyloric obstructions; and last, chronic gastric

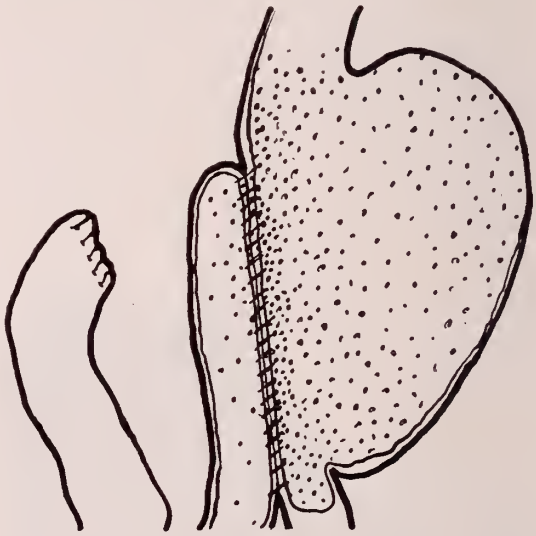


Fig. 6. Schematic representation of altered physiology in pyloric resection. Note the scarcity of acid. Legend: Black = acid; White = alkali; Shaded = admixture of acid and alkali.

ulcers which cannot be so completely cured that they leave no X-ray evidence of their former presence. It is impossible to say in any of the others that any given ulcer is not malignant or will not become so later.

Secondly, there are those which go immediately into the medical group, which are:

All acute, recently-formed ulcers of either stomach or duodenum; all chronic ulcers which come for the first time for a complete study, and have had no systematic, well-controlled medical treatment in the past, except those gastric ulcers associated with anacidity.

Someone has aptly said that we should have better indications for surgical treatment than "Perforation and Pauperism," indicating thereby that one's economic status has influenced some surgeons to advise operation because the patient could not afford the loss of time necessary to the carrying out of medical treatment. I think this is quite an important consideration. It has certainly proven its importance in my own experience. I think we must all admit that this problem, like many other ventures, does not work out as well in practice as it does on paper. It is all very well to say that we will place the patient in bed on the Sippey regime for six weeks, then guard the diet rigorously afterward, pumping out the stomach at weekly or bi-weekly intervals, testing for acidity for months, checking the X-ray appearance of the ulcer every few weeks, and if after all of this the ulcer remains, we will place it in the surgical column. Tell a patient this, however, and let him begin to figure up how much time, trouble and expense it will involve, and a considerable percentage of them will decide that they cannot afford (in the words of W. J. Mayo) "To make a pet of their ulcer." They want a short-cut to cure. A good many others will try it for a while and then get so tired of the restrictions as to diet, and as to their goings and comings, that they will prefer to take the risk of operation rather than continue with the medical treatment, and the more or less constant fear that the ulcer is going to perforate while they are out on a hunting or fishing trip in the woods. We must not forget that we are treating a patient with an ulcer, and not an ulcer with a patient attached to it.

When the patient is a candidate for operation, I feel that the choice of operation, like the choice between medical and surgical treatment, should be a very individual choice, based upon the general condition of the patient, the conditions found at the time of the operation, and that no single operation is always the best one. My own choice of operations is about as follows:

In small, simple duodenal ulcer, where the duodenum is mobile, or easily mobilized, I greatly prefer resection of the ulcer and the anterior two-thirds of the pyloric muscle with a pyloroplasty.

In duodenal ulcer, where the ulcer is large and thick, and the duodenum pretty well fixed, I prefer gastrojejunostomy.

If there has been much bleeding in the latter type, I prefer section of the stomach just proximal to the pylorus, closure of the ends and gastrojejunostomy rather than the more radical resection.

In gastric ulcer which has not been completely cured by medical means, I feel that resection is the operation of choice and the only one which should be done unless the patient's condition will not permit so radical a procedure. In these cases which cannot stand resection, I feel that the next best choice is cautery destruction of the ulcer with gastrojejunostomy or simply the latter.

TRANSURETHRAL RESECTION OF THE PROSTATE*

LOUIS ORR, M.D.,
Orlando.

The average peruser of current medical periodicals has probably read with considerable interest during the past several months the numerous articles and discussions appearing on the subject of transurethral prostatic resection.

Perhaps, too unfortunately, have the majority of these writings tended only to glorify the procedure and depict only the one side of a situation which most deservedly demands a just consideration of its merits and its deficiencies. It is perfectly true that the operation of resection of the obstructing prostate gland through the urethra opens a field of great promise to both the urological surgeon and to the sufferer with prostatism. I cannot help but feel that the method can only be evaluated for its true worth by two most valuable factors which make the pathway of scientific progress most certain, time and experience.

In the hands of those who have performed hundreds of this type of operation it has been conclusively demonstrated that the procedure of prostatic resection is here to stay. It does represent a tremendous step forward in the relief of prostatic obstruction. It opens a new field of preventive medicine and it is to be hoped that the patient with the characteristic urinary symptoms which precede complete urinary obstruction will

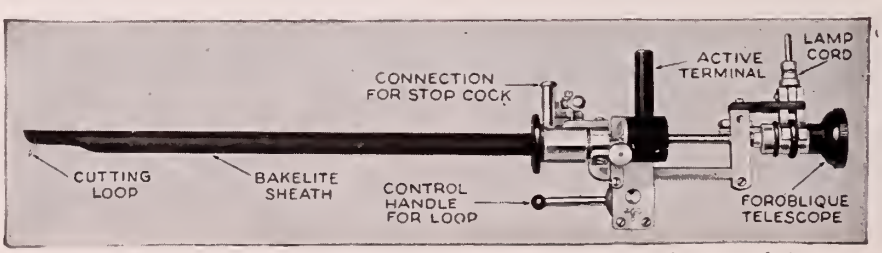
*Read before the 4th Annual Meeting of the Florida East Coast Medical Association, Jacksonville, Oct. 28, 29, 1932.

seek early relief rather than wait until irreparable damage has taken place and present the usual prostatic risk with which we are so commonly confronted today. It is likewise to be hoped that the family physician will be so acquainted with this procedure and its relative freedom from the dangers commonly associated with prostatectomy that the patient will be advised to seek early relief.

The history of the development of prostatic resection began as early as about 1825 when Civiale described in detail the median bar formation of the prostate. It remained for Mercier, however, at a somewhat later date, to design the first so-called "punch" instrument for removal of the bars and contractures of the bladder neck. Bottini, in 1874, attempted to apply the galvanic current in the form of a cautery to remove prostatic obstruction. In 1900 Fruedenberg equipped the Bottini instrument with a visual system which was the forerunner of the modern cystoscope.

The galvano-cautery instrument was used later on in this country by Fuller, McGowan and others, but the procedure proved unpopular because of its imperfection and all but fell into disuse. In 1910 Beer began to use the monopolar Oudin current to destroy certain bladder growths and suggested that it be used to destroy obstructing prostatic lobes. About the same time Young introduced a punch bearing his name which is only a modification of Mercier's instrument. This instrument proved generally unsatisfactory because of hemorrhage and poor vision of the bladder neck. Caulk in 1920 added the cautery punch which proved a great advance in controlling hemorrhage. Two years later Collings introduced the radio-electrotome for use with the bi-polar current for tunneling through bars and contractures. It was not until 1926 that Stern presented the resectoscope, the principle of which is embodied in all of the present day instruments. It is to his vision and inventive genius that all credit should be given for a contribution that has revolutionized surgery of the prostate gland. However, because of the lack of a suitable current for controlling hemorrhage and other structural defects the method was not enthusiastically received and very soon was all but discarded. During the following year the foundation work of Stern was taken up by Davis who by virtue of great mechanico-electrical ability was able to develop suitable currents both for cutting and the control of bleeding under water, likewise remedying many of the defects of the original Stern instrument. By the work of Davis has the procedure been brought up to its present standard of perfection and most certainly he is deserving of the highest praise to have carried on in face of the steady fire of criticism from all quarters. Through all this period McCarthy, in cooperation with Mr. Wappler, working upon the principle evolved by Stern, presented last year the McCarthy Resectoscope which now has come to be considered by many a superior instrument to the Stern-Davis.

The operating mechanism of the McCarthy instrument is of the same type as the Stern-Davis but has the advantage of a direct system of vision embodied in the McCarthy Panendoscope telescope which has long been a part of the armamentarium of almost every urologist. Another very superior feature of the McCarthy instrument is that the excursion of the cutting loop takes place from within out and the loop is seen as it makes the cut whereas the Stern-Davis loop moves from without into the bladder and the loop is only seen as it is placed against the tissue and cannot be followed clearly as with the McCarthy instrument. From my own experience, the fact that the McCarthy Resectoscope has no fenestrum into which the tissue must be forced but is so arranged that the loop can be placed at will out over the obstructing tissue at the open end of the sheath is a decided advantage. Much of the trauma and hemorrhage that oftentimes is occasioned by forcing tissue up into the fenestrum of the Stern-Davis instrument is thereby eliminated. Although Dr. Davis has been able to remove large bites of tissue with this type of fenestrum, I do not feel that his success has been shared with many others who have used both instruments and



The Stern-McCarthy Visual Prostatic Electrotome completely assembled.



The presence of so many small pieces of tissue as shown above represents the necessity of removing all small tags that may remain in the vesicle outlet. This patient had a residual of over 30 ounces which was completely relieved after removing 8½ grams of tissue.

the McCarthy instrument is being generally conceded to remove more tissue at each bite than the Stern-Davis.

As has been stated, the operation of resection has been made practical and possible by Davis in that he perfected the control of proper types of electrical currents for both cutting and the control of hemorrhage. In cooperation with manufacturers, a spark gap machine, known as the Davis-Bovie unit, was soon introduced, which housed both types of current and which proved eminently satisfactory. At about the same time the McCarthy-Surgical unit was announced by Mr. Fred Wappler, a tube type machine having also provisions for medical diathermy. This machine has rendered splendid results. The Westinghouse Electrical Company are also manufacturing a spark gap machine, the Endotherm F, which is for all practical purposes the equal or superior of the other two. It develops a splendid cutting current which is easily controlled and a coagulating current that is quite satisfactory for the immediate and complete control of any bleeding that might be encountered. The instrument is of small size and easily portable, thereby being a very great advantage to those working in different institutions not having equipment for prostatic resection.

Some operators have claimed the cutting current of a certain machine to be so superior that bleeding is so slight that a coagulation is only necessary at the end of the operation. This contention I believe to be unfounded and my feeling is that the pathological structure of the tissue to be removed is the prime factor in the amount of bleeding. I have found the greatest amount of bleeding is in the hyperplastic type of prostate and quite naturally the least bleeding in the hard fibrous type. The adenomatous prostates have proved somewhat vascular but when fibrous tissue changes have taken place the vascularity is markedly decreased. Another factor which seems to be important in the amount of bleeding is the rapidity in making the cut. A slow cut made at a regular sustained speed and carried through the entire distance before the current is released will greatly minimize hemorrhage. Not less than six to nine seconds for each cut should be used. Another factor which has not heretofore been emphasized that should tend to lessen bleeding at the time of resection is the proper amount of rest given the bladder and prostate prior to operation. The criteria of the amount of drainage to be given the patient before the operation has long been the amount of residual urine present and the amount of kidney damage as evidenced by kidney function tests and the nitrogenous content of the blood stream. The patient with a large prostate giving symptoms of great urinary difficulties without residual urine and with normal blood chemistry is generally considered safe for almost immediate operation. If the same rule applies to prostatic resection, the operator will have much more difficulty with bleeding than if the same bladder had been placed at rest with an indwelling catheter, and the prostate allowed to shrink in size which it will certainly do if it is given proper rest. It is my belief that congestion in the enlarged prostate is



9½ grams of tissue removed from a patient who presented a complete regrowth following an alleged prostatectomy 15 years previously. This illustrates the size of sections removed with the resectoscope.

not due to the presence of residual urine but to the constant irritation to which the gland is put in frequent efforts to empty the bladder. An enlarged congested gland without residual urine will reduce in size with proper rest as readily as the gland which has produced a large residual urine. Certainly if all candidates for prostatic resection are meticulously prepared in this manner the operator will have a much easier time performing the resection and more can be accomplished in a shorter period of time.

The operation of prostatic resection with its hospitalization period of from three to seven days and a mortality rate of less than one per cent can hardly be compared with the operation of prostatectomy with a hospital period of from several weeks to several months and a mortality rate among all the operators of about fifteen to thirty per cent. The great economic saving to the patient and the minimal risk involved is certain to cause a tremendous decrease in radical prostatic surgery and few patients, indeed, will submit to prostatectomy when resection will give the same results with no risk. In all fairness to the patient with prostatic obstruction he should certainly be given a most thorough urological examination to determine whether or not he can be relieved by resection and the time is not far off when every patient will demand it.

The modest number of cases upon which I have performed resections, some twenty-odd, hardly represent enough from which to draw conclusions. If it were not for the fact that others have shared like results in their earlier cases I would hesitate to relate my experiences; I cannot say that my work has met with the same glowing success as has that of Davis. His latest reports comprise over four hundred operations without a fatality and his postoperative results have been most excellent. I really feel that if Davis had encountered more difficulties and stressed more dangers of the procedure it would have been treated with greater respect and a great many patients would have been saved from disaster in inexperienced hands. I wish to stress the fact that the operation is not just a minor operation easily performed. It requires a thorough knowledge of the normal and abnormal anatomy of the prostatic urethra and bladder neck. The self-styled cystoscopist without surgical training who starts out with a resectoscope will soon find the path no easy one and very likely will come to grief.

The ages of the patients in my small series have varied between fifty-nine and eighty-three. I have had one fatality, not caused directly by the operation. I have had to open one bladder because of severe hemorrhage and have had one failure in that the patient could not void after the operation. In this particular patient I encountered a large pedunculated subcervical lobe which inclined to the right side of the vesical orifice. It had shaped itself so snugly up against the right lateral lobe that to all cystoscopic and endoscopic views it seemed to be a large lateral lobe. After removing about seven grams of tissue from this obstructing gland there appeared to be a quite satisfactory canal from the veru to the trigone. On withdrawing the retention catheter two days later the patient could void only a very small stream. Later, upon opening the bladder, it was found that the base of the lobe had been almost cut away and that the lobe moved over the vesical outlet in the manner of a ball valve. This same patient, representing my single mortality, expired at a later date because of infection which originated between the layers of the triangular ligament and produced a cellulitis between the fascial planes of the abdomen. The patient who necessitated cystostomy for control of hemorrhage was the second case in the series. I feel that the hemorrhage was due to too much haste and too rapid cuts being taken without proper regard for the control of bleeding. The gland was of the hyperplastic type and quite large, but without residual urine. The patient had suffered from great frequency over a long period of time and the tissue was most vascular even at the time of cystoscopy. After removing a considerable amount of tissue, I must confess more or less hurriedly, I found myself blinded by severe arterial bleeding. Several attempts to coagulate the bleeders proved unsuccessful and a rapid cystostomy was resorted to. The bleeding was quite readily checked by packing and sutures. The patient made an uneventful recovery and was able to void a large stream as soon as the cystostomy wound closed. The view of the bladder neck following resection was very interesting, but I trust that I have taken my one and only look under such circumstances.

The types of glands encountered have been varied. The majority have been bilateral and posterior-commissural lobe hypertrophy and next in frequency the posterior-commissural

type. Two rather dense bars and one sclerotic contracture were among the group. Strangely enough, no malignancies of the prostate were encountered in the series. Three cases were complicated by bladder stone, fortunately small in type and causing little difficulty. Three patients were examined during the period of this series and were judged unsuitable for resection. Two were referred back to their respective physicians and from the other I removed a tremendous prostate weighing six and one-half ounces. In refusing resection for these patients I based my decision chiefly upon the amount of intrusion of the lobes into the bladder and the length of the prostatic urethra. The rectal examination I have found to be of but little value in the determination of the amount of obstruction.

The freedom of these patients from post-operative shock and infection has been remarkable. In only two instances has there been a temperature as high as 103° with only slight chills. The



Model F Endotherm mounted on Mobile Table.

majority registered a postoperative temperature of about 100° which is not unusual for any urethral manipulation. There have been no renal complications whatever. There have been no instances of secondary hemorrhage necessitating coagulation. I have found quite a number of patients who have some slight terminal bleeding between the 10th and 15th day at the period when the coagulum begins to slough. After the operation a Robinson catheter, size 22, is usually put in place to give rest to the bladder and to lessen the chances of secondary bleeding. I have found the rule of not removing the catheter until the urine is fairly clear as the most satisfactory to follow which is usually within 48 to 72 hours. Some patients will void a strong, forceful stream at once, whereas others, because of edema of the outlet will void only a small stream which improves in size and force as the edema subsides. There have been several patients who had some dribbling and loss of control following operation from which they recovered in a few weeks. All patients have been able to void a good forceful stream and none in so far as I know have shown any diminution since operation, but only a few months have elapsed since the first resection was done.

The anesthesia used in these cases has consisted of injections of procaine hydrochloride into the lowest spinal foramen. The administration of from 100 to 150 mgs. of this drug has given excellent results. The fall in blood pressure has been found to be negligible provided the solution is administered quite slowly. The anesthesia produced will retain its effectiveness for two to two and one-half hours. A low spinal anesthesia is more quickly and much more easily administered than the combined trans-sacral and caudal injections and certainly gives the highest degree of so-called block anesthesia obtainable. I feel that it only remains for the fear so many have of spinal anesthesia to be dispelled before it will supersede entirely the trans-sacral method.

At this point I would like to mention the air cystogram as a valuable diagnostic adjunct to the cystoscope and rectal examination in the determination of the amount and relation of obstructing tissue. The method has long been stressed by Ballenger and gives an excellent view of the amount of prostatic tissue protruding into the bladder and enlarges one's comprehension of the obstruction considerably.

The amount of tissue removed has varied from 1½ grams in the bar formations to 8 grams in the adenomas. Davis states that he has removed as much as 45 grams at one operation, but many urologists are questioning the advisability of

attempting to excavate the entire prostate gland. Caulk, through years of work and teaching, has shown conclusively that the removal of small amounts of tissue which constitute the actual obstruction will result in the decrease in the size of the gland which in many instances has proven permanent. McCarthy likewise feels that it is the release of the intracapsular tension which relieves the congestion of the prostate and causes the gland to decrease in size. If this be true the operation of prostatic resection will become a tremendous success and its results will be equal, if not greater than total prostatectomy. Davis reports that 25 patients in his series had previously had prostatectomies performed and feels that that particular fact is a triumph on the side of resection. In this he will not find many in accord for it is only reasonable that if the gland will undergo a complete regrowth from some small bit of unremoved prostatic tissue following prostatectomy a regrowth following resection will be all the more rapid for only a relatively small proportion of the prostate can be removed. Only time will give us our true results and as yet no one is in a position to be positive as to what will happen to the patient with a resected prostate 10 or 15 years hence. But whatever that result may be, repeated prostatic resections are far more preferable than one prostatectomy. When more is known, as undoubtedly soon will be, about the pathology of prostatic obstruction, not from a standpoint of what the microscope reveals but from a standpoint of the rate of growth of the different types of cellular elements of the prostate under different conditions, then can we be dogmatic in our claims.

RELATION OF THE CANCER PROBLEM TO PUBLIC HEALTH*

GERRY R. HOLDEN, M.D.,
Jacksonville.

As a public health problem, cancer differs materially from that of many other diseases since the question of contagion, or transmission from person to person, is not involved. Therefore, there is no consideration of any specific preventive measures whereby the occurrence of cancer may be prevented and the spread of the disease thereby controlled.

The interest of public health in this condition depends not only upon the high mortality rate of cancer, as shown in vital statistics, but also on the fact that within recent years this mortality rate has been increasing rapidly.

In 1900, tuberculosis, with a mortality rate of 201.2 per 100,000, took first place among the causes of death in the United States, while cancer, with a mortality rate of 63, stood in sixth place. In 1929, tuberculosis had fallen to sixth place with a mortality rate of 76, while cancer had risen to second place with a mortality rate of 96 per 100,000 population, an increase of 52 per cent for a 30-year period.

In Florida vital statistics, as supplied to me by Dr. Thompson, show an even more rapid rise in death rate. In 1917, the total deaths were 378, a rate of 41.4. In 1926 the rate had risen to 68.3 while in 1931 the total deaths were 1,072, a death rate of 71.2 per 100,000 population; an increase of 69½ per cent for a 14-year period.

These figures should not be interpreted as meaning that the actual number of cancer cases in existence have really increased at this rate. A number of factors must be considered before drawing final conclusions. Great improvement has taken place in the collection of vital statistics. The great advances which have been made in medical education and the training of physicians have made the average doctor a much better diagnostician than he was some years ago. More cancer cases are recognized today. Moreover, due to improved conditions, we now have a larger proportion of our population of the "cancer age," middle life and beyond. This last factor applies especially to our own State, on account of the large number of the middle-aged who are included in our annual tourist population.

While these factors must account for some of the apparent increase in the number of cases, it seems impossible for them to account for all. It is generally conceded that, in spite of improved methods of diagnosis and treatment, and in spite of the efforts made to get cancer cases early when they have a chance of being cured, cancer, both from the standpoint of numbers and of percentage, is actually increasing.

The problem of controlling cancer, of reducing in some way the enormous number of deaths which are caused by it, naturally differs from that of many other problems of public health. It is hampered by the fact that the ultimate etiology of cancer is unknown; that cases must be reached in the early stages if they are to be cured; but more than anything else, it is hampered by ig-

*Read before the 4th Annual Meeting of the Florida Public Health Assn., Ocala, Dec., 1932.

norance on the part of the laity. Occasionally, I am sorry to say, it is also ignorance or negligence on the part of the physician himself.

Cancer is one of the oldest known diseases. Undoubted cases of cancer are mentioned in the Bible. We are told that the Egyptians were familiar with it and that the earliest writings of India make mention of it. On down through the ages it has been known, recognized, and dreaded.

It is not to be wondered that there has gradually accumulated, during all these years, a vast number of erroneous and absurd ideas about it, ideas about its cause, its nature, its treatment, and its course. Many of these false conceptions, passed on to us from the ignorance of former years, are some of the greatest stumbling blocks in the control of cancer today.

The erroneous notion that cancer is an hereditary disease, that because a parent died of cancer the offspring would necessarily suffer from it, is widespread. This idea is wrong. While we do occasionally find families in which the repeated appearances of cancer in various generations seem to lend credence to this impression, such incidences are rare and by no means prove the case. Cancer is not an hereditary disease.

Much misery and mental distress are caused at times, both to patients and their families, by the beliefs that cancer is contagious, and that there is something degrading about it. Many patients hide the fact that they have cancer through feelings of shame.

The public mind should be disabused on both of these points. Cancer cannot be transmitted from person to person by any of the ordinary contacts of human life. Neither can any possible disgrace be attached to the cancer sufferer.

One of the most pernicious of these traditional fallacies is the idea that the treatment of cancer is always unsuccessful. How often do those of us who are seeing a large number of cancer cases hear the awful dictum that, "There's no use doing anything. Cancer never can be cured." Many a cancer death is due to the delay caused by this erroneous notion.

Of course, we admit at once that, with our present knowledge, cancer can be cured only if treated before a certain stage in its growth has been reached although at the same time we must also claim that, even in advanced cases, much can often be done to mitigate suffering and even prolong life.

Theoretically, every cancer can be cured if it can be recognized as cancer while it is still a local disease, before it has been carried from its initial site to other parts of the body, provided that the surgeon is able to completely remove every portion of this initial growth. If attempts to cure a cancer are unsuccessful it simply means that one or both of these two conditions could not be fulfilled.

Also, while we frankly admit that, under present conditions, a large proportion, possibly the majority, of all the cancer cases treated or operated ultimately die of the cancer, nevertheless, medical science has an extensive armamentarium of therapeutic measures with which we do entirely cure a large minority of all cases that come to us, and a majority of all cases that come to us in the early stages.

With the treatment of cancer we shall not today concern ourselves. It is indirectly a concern of the public health in that improved methods of treatment and improved facilities for providing such treatment to the cancer sufferer at large will cut down the mortality. But in the State of Florida, therapeutic measures are fortunately still left in the hands of the private physicians, either working directly as physicians of individual patients, or as staff members of our various hospitals, giving their services without charge to the cancer patients in those hospitals.

The field of preventive medicine and early diagnosis is very much within the province of public health work, and here public health agencies can greatly aid in the effort to reduce this cancer mortality.

A few moments ago, I said that the ultimate cause of cancer is unknown. That is true. We do not know why certain causes, certain stimuli, should make normal tissue cells change their orderly manner of growth and suddenly become transformed into those abnormal cells which we recognize as cancer cells. But if we do not know how these causes act, we do at any rate know what many of these causal factors are. Then by eradicating these causes before the cancer ever starts we are actually preventing the appearance of cancer and are helping to cut down its death.

To illustrate: We often have cancers developing in parts of the body that have been the location of long continued chronic irritations and inflammations. This is so frequent that we consider such chronic irritations as predisposing these parts to the formation of cancer. Irritations of the tongue, or the inside of the cheeks,

often terminate in this way. These may be due to the irritations of ill-fitting dentures, jagged or decayed teeth, excessive use of tobacco, etc. If then we relieve these conditions by attention to the teeth, proper dental work or moderation in the use of tobacco we are doing prophylactic work toward the reduction of the cancer mortality.

The field for this type of work is wide. Many different types of cancer may arise from this cause. Skin cancers frequently arise in some pre-existing skin irritation. For example, long continued exposure to the sun and weather may bring on, especially in people of the blonde type, lesions which finally end in skin cancer. Such cancers are found in Florida among our outdoor workers, fishermen, farmers, truck-growers, etc., who unduly expose themselves without protection to the hot rays of the sun.

Cancers of the lip often occur at the spot where a favorite pipe has irritated the mucous membrane for many years. The old clay pipe of our grandfather's days was a potent cause of cancer of the lip as its rough stem had a peculiarly irritating effect on the delicate tissues of the lip. In the genital tract of women chronic irritation is a potent factor. The majority of all cancers of the womb begin in an old tear of the neck of the womb which has been neglected and has become irritated. Also, we may have an irritation beginning in the pre-existing growths, such as some types of moles, which turns these growths into cancerous processes.

Other irritations exist which are at times less easy to diagnose than those previously mentioned. A certain proportion of gastric ulcers become cancerous in their later stages. The same is true of some cases of chronic irritation of the gall-bladder, and of the prostate gland.

Enough has been cited to point out the way by which preventive medicine can help in reducing cancer mortality by preventing the cancer from starting. Education of the public to a realization of the potential danger of such long-standing irritations is one of the important factors in preventive medicine.

A moment ago, mention was made of the fact that certain types of moles and other benign skin growths may at times become malignant. This phenomenon is an illustration of another type of pre-cancerous lesions. Certain pre-existing growths, originally not cancerous, for some reason or other, may later develop into cancer. Various skin growths fall into this category. So also do some tumors of the thyroid gland, prostatic growths, and certain uterine tumors. More frequently do we see cysts and tumors of the ovary, sometimes after many years of slow and innocent growth, become transformed into malignant tumors.

While it is true that the great majority of the various growths just mentioned do not become cancerous, yet a certain proportion do undergo such a malignant change. If this knowledge could be so imparted to the public that the average man or woman would take the proper measures for self-protection, we would advance another step toward the reduction of cancer mortality.

Passing from the domain of preventive medicine to that of actual treatment of these conditions it is necessary to emphasize again the importance of early diagnosis. Unless we can get the growth in its early stages, before it has become generalized, we cannot hope to radically cure it. In this lies the importance of a careful and thorough examination and an exact diagnosis in those cases which may be early cancer.

While many cases in the first stages can easily be recognized as cancer, this is not always the case. Sometimes even the skilled diagnostician has difficulty in deciding whether or not a given condition is malignant. How much more frequently, then, does the physician who does not see many cases of cancer, or the physician who, for one reason or another, fails to give as exhaustive examination as he might, miss the diagnosis.

It is easy for the physician not trained in laryngoscopy to consider that the hoarseness of a cancer of the vocal cords is due to a chronic laryngitis. The bleeding of a rectal cancer may be diagnosed as hemorrhoids. Sarcoma of the bone may be mistaken for rheumatism. It is impossible to diagnose certain breast tumors until a bit has been removed and a frozen section examined under the microscope.

These examples of the occasional difficulties in early diagnosis, even at the hands of skilled men, emphasize still more strongly the vital necessity for impressing on the minds of the laity the great value of early examination whenever suspicious symptoms occur. As a corollary to this the public must be given some knowledge of what these early suspicious symptoms are.

For 30 years or more various individuals and organizations have been endeavoring to impart such knowledge to the public about cancer. It is slow work, oftentimes very discouraging. Nevertheless, much has been accomplished. Before this educational program was instituted the ma-

jority of all cancers of the womb applied for examination only when the growth had become extensive and inoperable. This was also true of cancer of the breast in a lesser degree. Such a thing as a woman voluntarily coming to the doctor's office to be examined for cancer, was practically unheard of.

Today the picture is very different. For women to come to the gynecologist's office with the question, "Have I got a cancer?" has now become an almost everyday occurrence. To be sure, the great majority have no cancer, but not all. Every now and then an early cancer of the breast or the uterus is discovered in this way and the woman is given a chance for her life which she would not have had otherwise.

This educational work is slow and requires many workers. National organizations are carrying it on, State and civic bodies, medical associations and societies of various sorts. In my work with nurses, in lectures and other forms of instruction, it has always seemed as if they were to be, in a sense, missionaries. Women talk to other women at times more freely than they will to a man. Every woman in any way connected with medical work or the public health work is often in position to impart information which may be of the greatest value, which may save the life, perhaps, of the questioner.

May I, then, in conclusion, recapitulate some of the essential points which I feel that every person should know about cancer, and shou'd be willing to impart to others should the occasion arise.

Any sore or ulcer which runs a chronic course and will not heal should be examined by a competent physician.

Chronic irritations or inflammations in any part of the body demand measures to relieve them. This is especially true in irritations about the mouth, tongue, lips, inner side of the cheeks.

Chronic skin irritations should be relieved. Persons with delicate skins, especially of the blond type, should not permit long exposures, day after day, to the sun or wind without first properly protecting the skin.

Certain growths, which appear to be non-malignant, should at least have an examination before allowing them to remain, as they may develop into cancer. This is especially true of certain types of warts and moles.

Symptoms of rectal trouble should not be neglected. While a self-made diagnosis of "piles" may be correct, the symptoms may be those of rectal cancer.

Especially should the symptoms of cancer of the womb be reiterated. Because of the phenomenon of normal menstruation, women are so accustomed to vaginal bleeding that they do not realize how significant the appearance of any abnormal flow may be. It should be emphasized that this may be the first recognizable sign of either a malignant or a benign growth. Hemorrhage at the age when the change of life usually occurs is not a symptom of the change of life. Neither is a bloody flow, appearing sometimes after the change has occurred to be interpreted as "a return of menstruation."

THE SIXTIETH ANNUAL MEETING

OF THE

FLORIDA MEDICAL ASSOCIATION

WILL BE HELD AT

HOLLYWOOD

MAY 1, 2, 3, 1933

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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A number of years ago when paved streets were first laid in Tallahassee, a man was discovered in the wee sma' hours seated on the curb, actively engaged in haranguing an imaginary audience about honesty of purpose and the duty one owed to his constituency. When asked by an inquiring bluecoat just what he was doing here, he replied with dignity, "I am representing Orlando."

We are now selecting men who will represent us in the house of delegates at our annual meet-

ing to be held in Hollywood in May. In this house last year a precedent was set in that a person desiring to address the house, if he were not a properly seated delegate, had to obtain permission from the body. If this method of procedure is to continue—and we believe it should—much valuable time could be saved, if individuals, who are qualified to speak with authority, should be elected as delegates and to those individuals should be handed, for introduction, any matter which a component society wished brought up, thus discouraging extra corporal speaking. This, the ruling body of the society, is always rushed for time, and overcharged with work, so every moment that it is in session should be conserved and not wasted by this injection of unseated speakers and of oratory, often of a meaningless type, on some subject which a regularly elected delegate could and should have introduced.

It might even be well to have the house of delegates meet only in executive session. Then each county would be desirous of sending as a delegate only its strongest and best informed men—men who could and would truly represent, and not men who meaninglessly waste not only their own time like our curbstone friend, but also the time of others, which tests the temper, even of angels.

RADIO BROADCASTS, 1931-1932

The following broadcasts were arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

A FLORIDA DOCTOR'S CONTRIBUTION*

EDWARD JELKS, M.D.,
Jacksonville.

Records of the human race from earliest times describe epidemics of fevers which are transmitted by mosquitoes. When Rome, in the glorious reign of Commodus, was at the height of her happiness and prosperity, malaria was so prevalent that some authorities believe it to be a chief cause of her disintegration and fall. Recent researches in Central America justify the opinion that an advanced civilization which had flourished centuries before the landing of Columbus, had been wiped out by malaria and other mosquito-borne fevers.

Never again will the world suffer these tragic scourges. For, about fifty years ago Ross and Manson proved that malaria is transmitted by the mosquito. Until their epoch-making work, the world had been in utter ignorance concerning a sensible handling of malaria. But during the past centuries science and scientific curiosity had not been idle. Many theories about malaria and associated fevers and many remedies for treating them had been advanced, before a Florida doctor, Dr. John Gorrie, conceived the idea that to prevent them it was important to cool the air in which one lived. With this opinion in mind he worked for ten years upon a machine which would provide the devised temperature. The result was he made ice.

For the first time in history artificial ice was served in public on July 14, 1850. This was at a dinner in Apalachicola given by the French Consul, Monsieur Rosan. Representative citizens of north Florida and south Georgia had gathered there at the old mansion house to celebrate the French national holiday, Bastile Day.

The guests did not know that Dr. Gorrie was to furnish ice for the cooling of the wines, so when Dr. A. W. Chapman rose to drink the toast, "My friends, we will now toast our own country, an American has produced the ice, which will cool this champagne." The guests were skeptical. No one saw any ice.

Monsieur Rosan sprang to his feet and said, "This is the day when France began giving her people what they want, so if my guests want ice, they must have it, even if to feed them, we work a miracle . . . Only this time, it is an American who has worked our miracle." At these words, four waiters entered, each carrying a silver salver upon each of which rested a cube of ice.

Dr. Gorrie's ice machine was patented in 1850. It was based upon the principle that gases, when permitted to expand rapidly, absorb heat from substances about them. The machine consisted primarily of a pump which increased the pressure of air in a chamber. Within this chamber was placed a container filled with the water that was to be frozen when the air was permitted to expand quickly.

While we are interested in the dramatic introduction of artificial ice, and charmed by his romantic life, the real story of Dr. Gorrie centers about the problem of the sub-tropical fevers.

*Broadcast delivered under auspices of Florida Medical Association, over Station WRUF, Gainesville, October 14, 1931.

When at the age of thirty he arrived in Apalachicola, Florida, in 1833, malarial and associated fevers were taking many lives yearly and threatening the successful colonization of the section of Florida along the Gulf of Mexico.

Dr. Gorrie stated a number of facts which were generally known in his time concerning malarial and sub-tropical fevers. These facts we recognize as true today; but we know now that their explanation lies in the truth that the diseases are borne by mosquitoes. It was known then that malaria occurred about low places, that it remained within a circumscribed radius, that it was very infrequent at high altitudes, that clearing up and draining the country diminished its occurrence. It was also known that when persons slept under nets they rarely had the fever. Dr. Gorrie explained that this was because of a sifting property of the cloth material and did not suspect its virtue was that it kept away mosquitoes. In brief, he explained the known facts on the theory, that the cause of fevers was a volatile oil, which was formed in low swampy places by the decomposition of vegetables and animal matter. The vapors from this oil, when reaching the lungs of an individual, caused the fever. For the transmission of the fevers two primary conditions had to be present:

1. Organic matter had to decompose in order that the harmful volatile oil be formed.

2. A specific temperature had to be maintained for proper volatilization of the oil. An explanation as to how this second condition worked puzzled him a great deal. For it was observed that in very hot dry weather the fevers were not so prevalent, and when the temperature was very low, as in the winter time or in northern climates, the fevers would not be present at all. He argued that in excessive heat the oil would volatilize too rapidly to cause disease, and that at low temperature it would not vaporize sufficiently to cause disease.

For the prevention of the fevers, Dr. Gorrie urged: first, thorough sanitary engineering to prevent stagnation of water.

Secondly, he recommends that since these fevers were contracted during warm nights, individuals should sleep in rooms which were kept at a definite cool temperature. It was by an ingenious arrangement that Dr. Gorrie hoped to acquire this ideal environment. His plan was to use a room without the usual openings of windows and doors. At the floor level in one wall was to be made an opening. From the ceiling in one corner there was to be hung a bowl containing a block of ice. Over this was placed a cone-shaped hood connected up with a vent pipe, which passed through the ceiling into the chimney. The idea of the apparatus was that the cool air from the melting ice would descend to the floor of the room and then pass out through the opening there. If this took place there would naturally be a suction of air through the vent pipe downward over the ice, where it would be cooled. The air before entering the vent pipe would pass through the chimney, where the soot carbon acting as a filter would withdraw some of the impurities which the air contained. This circulation of purified air which had been cooled, passing continuously in from above and out from below, would keep the room at a desired temperature. Undoubtedly, had people slept in a room where this scheme of ventilization and refrigeration was utilized, they not only would have had cool summer nights but would have been safe from malaria, since mosquitoes could have gained access only rarely to such a room.

The State of Florida, to honor her illustrious son, Dr. John Gorrie, has placed his statue in Statuary Hall, Washington. It bears the dates October 3, 1803-June 16, 1855, which mark the span of his life. Although there is a great deal of uncertainty about his early years, it is usually agreed that he was born in Charleston, S. C. He died and was buried in Apalachicola, Florida. His early education was obtained in Charleston. Arriving at Apalachicola in 1833, he was for the following twenty-two years active in the life of the community. He was on the board of directors of several business organizations, and also served the city as its mayor. In 1839 he married Mrs. Caroline F. Beeman. By this union there were two children, a son and a daughter. Through the daughter there is a granddaughter who today lives at Milton, Florida. She told the writer that her mother characterized the last years of Dr. Gorrie's life as being almost completely devoted to the problem of perfecting a machine for producing artificial ice with which to treat fevers.

Dr. Gorrie did not live to see his ice machine put into practical use. Neither did he live to learn the true cause of the fevers which he studied so earnestly. Although he devoted his life to a false explanation of what caused malaria and sub-tropical fevers, his endeavor to secure a ready supply of material with which to prevent and

treat them resulted in his giving to the world artificial ice. He was the forerunner of modern refrigeration.

THE FLORIDA MEDICAL ASSOCIATION: WHAT IT IS AND THE VALUE OF ITS INFLUENCE TO THE STATE*

T. Z. Cason, M.D.,
Jacksonville.

The purpose of the Florida Medical Association is clearly stated in the second article of its constitution, which is in part as follows:

"The purpose of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida . . . with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of State medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life." It is not the purpose nor the object of this organization to regulate any individual or group of individuals.

The smallest component part of the medical organization in the State of Florida is the county unit, which is designated as the County Medical Society. In some instances the smaller counties have grouped themselves together to form such a unit. No physician can be a member of the state or national associations unless he is a member of his local society. The state organization, in turn, is a part of the larger organization, the American Medical Association. The size of its representation in the national association depends on the number of members belonging to the state organization.

Unfortunately, the records of the Florida Medical Association prior to the year 1901 were destroyed by the Jacksonville fire occurring in May of that year. The best available records show that the association was organized in 1873. No authentic information is at hand to indicate the personnel of the charter members or the place of its organization. During the first 20 years, the association made little progress. This was no doubt due to poor transportation, for it is recorded that prior to the year 1890 the best route by which a member living in the western section of Florida might reach the other portions lay by way of Montgomery, Alabama, Thomasville and Waycross, Georgia.

The state association now has thirty-four component units and a membership of approximately one thousand physicians. Its greatest growth has been in the last decade. As far as available information indicates, the Florida Medical Association has actively supported the functions of the official health agencies in the State of Florida. This organization has also aided, both officially and through its individual members, properly organized, volunteer health agencies such as the Florida Tuberculosis and Health Association, Red Cross, etc., thus forwarding its activities along the line of preventive medicine. The state medical association has constantly endeavored to raise the standards for admission for physicians to the state and to keep out charlatans and quacks. As a result of this, the health standards of the state have been necessarily raised.

Since the beginning of its organization, the members of the Florida Medical Association have never failed to respond to the call of charity when medical services were needed. In the State of Florida today all organized charity medical services are rendered by these physicians. Most of this service is given without remuneration and in many instances at a cost, other than time, to the doctor.

By its own declaration, it is committed to the enactment and enforcement of just medical laws. At no time has the Florida Medical Association promulgated or fostered any laws in which the public was not given the first consideration and wherein the public would not primarily benefit. Possibly all members of society will not agree to such a generalization, but the final analysis by an unbiased, thinking individual must prove the correctness of this statement.

The state medical association has undertaken its educational work by holding annually a statewide scientific meeting at which time its members have a free interchange of ideas. Prominent physicians from other states are invited to be guest speakers at these assemblies. All of this is

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, November 11, 1931.

done to increase the knowledge and improve the skill of your physician in order that he may render a better service to you. The second phase of this work is the education of the individual patient as well as various civic groups. It is the belief of this organization that the more correct knowledge the public acquires the higher standards it will demand of its physicians, and the more readily it will participate in further medical progress.

While it is true that this or any other similar organization can not be of any greater value than that of the individual members to their patients, when these same individuals with high ideals, lofty purposes, and the will to do, group themselves together, they can carry out a greater work and materially increase their value to the state as a whole. However, the ultimate value of the Florida State Medical Association must rest in the worth of its individual physicians and their relations to their patients.

THE MEDICAL PROFESSION*

G. H. Edwards, M.D.,
Orlando.

The practice of medicine appeared almost with the beginning of social living and possibly, out of a desire on the part of some unusually sympathetic individual, to help those who were sick, physically or mentally. Some time later, when the individuals began to be differentiated into groups, such as moneychangers, butchers, artisans, coppersmiths, etc., the sympathetic ones became the priest doctor or the doctor priest.

Records of distinct diseases and their treatment have come down to us from more than three thousand years before Christ. Assyrians were probably the beginners in accumulation of medical lore and information, but it was not assembled, as a whole, and put into form for the physicians' use until 400 B. C., when a Grecian, Hippocrates by name, did it. Since then, medicine as a science has been undergoing constant changes in an effort to get a true knowledge of the fundamentals of disease. This has been hampered by the fog of superstition, which was for ages thrown around the healing art. But great progress has been made and not the least active factor has been organized medicine, as represented by the State and County Societies, whose efforts are to place before the skeptical ones definite knowledge—explanations of seeming miraculous cures, the penalty for carelessness, the reward of cleanliness, etc.

From the beginnings of medicine as a science, the physician was concerned with the individual, the one who because of some accident or disease was for the time being thrown out of his usual routine. The ancients always thought, and even today many an unfortunate thinks, of illness not as a result of thoughtlessness or neglect on his part, that is, a sort of punishment, but rather as a blow showing displeasure of the gods or an act of Providence, which they could in no way avoid.

It is curious how an individual will take to himself the symptoms which may be advanced in a lecture or discussion or a patent medicine advertisement and fit them into a picture of himself. Medicine seems to be a much more personal thing than either theology or law. We hear discussions of the latter from a most impersonal standpoint; but, not so with medicine. None of us are created physically or anatomically perfect, nor have we developed perfectly and subconsciously we know it, so, when a disease is discussed, especially a new one, we are assailed with doubts and fears.

During the past fifty years, methods of diagnosis have increased in accuracy and the part temperament plays in influencing the severity of symptoms has been recognized. This, in turn, may have been influenced early in life by certain agencies as air, food, and light, which changed development and helped to differentiate the individuals, and it is this individuality which makes the practice of medicine such a difficult art. A study of these factors and results is leading us, as physicians, to a wider appreciation of the importance of preventive medicine, which really is but a study of disease in its very earliest beginnings and directs attention to the day-by-day life of the people and the conditions that surround them.

Probably the best method to prevent disease is not only by yearly physical examinations, to keep the individual informed about himself as to his limitations and needs and how to regulate his life in regard to food, drink, work, play, exercise, etc., but also how to protect himself from infectious diseases; the baleful results to others of his carelessness and neglect; and the part these latter play in the dissemination of disease.

Science dominates the world today, that means study, research, observation, and the recording and assembling of valuable information, for use.

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, December 30, 1931.

Ignorance is responsible for the large number of fraudulent schemes to separate the sick from their money. When vital tissues are destroyed by accident or by disease, medicine can not replace them. A deformed heart valve, a lost leg, an atrophied optic nerve are irreparable, but the physician has much to offer the patient to help him endure his handicap, prevent recurrences or new disturbances and make life more enjoyable.

The duties of the physician are two-fold: first, to practice medicine so as to give his patients all the benefits of the advancement of medicine, and second, to help increase the bounds of medical knowledge, not for the physician alone, but to place it at the hand of the sick individual, that he may better understand what his physician means when certain phrases are used and why a certain routine is instituted, which may not alone benefit the sick one but may aid in the protection of others. From this activity the physician does not benefit personally.

During the past twenty-five years or more, the progress of medical science has been so rapid that one individual could not keep up with it all, especially in the detail necessary to intimate knowledge of both cure and prevention. This has led members of the medical profession to help organize many different types of health associations or groups throughout the country, all having the same ultimate end, the relieving of human ills, and the prolonging of life. They may be divided into three groups, dealing principally: first, with preventive medicine; second, therapeusis; and third, which is distinctly of interest to the lay mind, education.

The members of the Florida Medical Association have to date taken little active interest in any of these groups or in any health agencies or activities, save the second, therapeusis, the reason being that many of the leaders of the profession felt that their special work was being encroached upon and that we were drifting into State medicine; while on the other hand, some health agencies were somewhat exclusive and failed to take many practicing physicians into their confidence. But times are changing. You now find all physicians striving as earnestly to prevent disease as they do to cure it.

The individual physician is a busy man clinging probably too much to old methods and friends, so to many of them anything new which contacted with their special line was often considered a mere set-up, placed there to be knocked down. They would brook no interference and would not associate with any agency, looking toward the amelioration of illness, outside their own group. On the other hand, many of the health agencies have considered themselves able to develop and function with the aid of but few physicians. Now while both are wrong, although pointing toward one and the same target—the relief of human suffering—they would make each more sure of success by working more in unison.

The physician diagnoses and prescribes for the individual while the health agencies have in the past looked after mass diagnosis, by way of contradistinction, have dealt with prevention and offered education to the masses. This requires a certain financial backing. Now physicians, members of the local county societies, are taking places on the various groups. Straight medical problems are theirs while the more involved economic ones, as education and demonstration, can better be handled and cared for by the health organization.

It seems that in the past the tendency has been, on the part of the lay organization, to secure the services of one or but few physicians in a county to carry on their work, and these in some states frequently are not members of the State Medical Association. Today we feel that it is better, by cooperation between the State Association and the health agencies, to give to the entire profession a chance to work on these problems.

A physician should have, in addition to a comprehensive knowledge of his subject, love for his fellowman and many qualities of a broad-minded churchman. He should have sympathy and an imagination which leads him to understand the needs and anxieties of those who come to him for aid. To be methodical, punctual, cheerful, optimistic, tactful, possessed of a good memory and common sense are traits almost indispensible in a successful doctor. He must be so schooled that the crudeness and often the repulsiveness of human nature will not blunt his sympathy, distort his vision nor lessen his enthusiasm and interest. He should set an example as to temperance, personal hygiene, exercise and recreation, for they are necessary to good health—the very thing he is trained to produce and conserve.

Always has the physician been willing to give his services; to treat all who come to him without question as to color, race, or belief, and with almost an indifference as to whether the services can be paid for or no. He has taken pride in

serving clinics, public school classes, hospitals, etc., and now he steps out, it seems to me quite unselfishly, to instruct the public in health matters and how to avoid the very things his training has fitted him to cure. Unheard of unselfishness—which is converting the physician from a therapeutist into a preventionist. I believe we have reached the point where the physicians see the value and almost the necessity for health organizations to round out their work, and the latter will see their work only begun, unless the medical profession, as represented by the State Association, is taken in to help finish it. Members of the State Health Association, through the County Medical Society, have put on several demonstrations or public health programs, to show what can be uncovered that is detrimental to health and how the condition may be remedied. The success of these would indicate that an intensive campaign among all or many phases of public health work, carried on over a period of years, by an efficient medical organization well financed, cannot but help to raise the standards of health and reduce morbidity and mortality. A truly worthwhile job—one which will confirm the statement by Dr. Herman Biggs that "Public Health is purchasable, so that, within natural limits, any community can determine its own death rate."

Times are changing. Instead of being trained to ameliorate symptoms only, we now are trained as well to prevent the inception of the disease itself. Our public is looking to us more and more for guidance in accepting methods designed to prevent disease. If by public and popular health education we can reduce the incident of such preventable and communicable diseases as diphtheria, scarlet fever, rheumatoid infections, yes, and the common cold—common because of its prevalence and not because it is not dangerous and often disastrous—we will be contributing much to the lowering in later years of cardiac and renal diseases. In his introduction to Tristram Shandy, Lawrence Sterns says, "He who smiles, but much more, he who laughs, contributes something to this span of existence which we call life." By properly conducted and intensive educational work, we physicians will be able to add much—in terms of years—to this span of existence, especially extending the later portion.

THE MEDICAL PROFESSION: ITS CONTRIBUTIONS TO CHARITY IN THE STATE OF FLORIDA*

RALPH N. GREENE, M.D.,
Jacksonville.

As the voice you are hearing enters your home, you understand that the topic is being discussed by a physician who deems it an act of impropriety to speak in laudatory terms of the charity work accomplished by the profession which he represents.

Charity work from the viewpoint of a physician's evaluation of the services rendered may be divided into three broad classifications.

Doctors are called into homes to minister to the sick and to the suffering. There the physician renders not only a professional service but is enabled, because of the intimate position which he occupies at the hearthstone, to render counsel and advice which has to do with the moulding of not only the individual and family affairs but with community affairs.

Doctors in an analysis of the affairs of mankind are inclined to the belief that every nation has a definite financial standard of gold, silver or other metals. In mapping out the business problems of corporations, the money to be expended is the basis upon which the foundation is built. Likewise, in the affairs of human families, a contemplated activity must be based essentially on the probable cost and the value of the results obtained.

Aside from the charity program which is carried out in the home are many activities which lead the doctor into the highways and byways and into the remote places, ministering to human suffering. He has likewise to foster and assist in the development of the public health program. Many of you who are listening are mature enough to remember a time not so far distant in the past when yellow fever was rampant in the land; when smallpox was taking a terrible death toll; when typhoid was stalking through the land like the grim reaper; and can also remember many other epidemic diseases which, because of improved sanitation and preventive measures in general, that which we concretely term our public health program, has brought about a definite expanse of the span of human life and has rewarded humanity with a definite assurance of increased longevity, less suffering, a lessened degree of

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, January 6, 1932.

chronic invalidism and, in general, a condition of public health, happiness, security and prosperity. Doctors who worked in the public health program, frequently making the supreme sacrifice, were not unmindful of the fact that during those trying times there was a means of prevention and in company with the large army of workers who assisted them, they developed a program of preventive medicine.

Preventive medicine has reached a degree of development which now enables the doctors to say to humanity at large that the problems of human living today do not rest with the curing of the sick but rather with the duty of guarding against degenerative illnesses and preventive illnesses.

It has come to be recognized that the best results in treating the sick cannot be accomplished by the doctor at the bedside in the home, the home being more often than not that which we emotionally speak of as "ever so humble." In the recognition of illnesses and in the exact diagnosis of the particular sickness under consideration, and in order to secure the most highly satisfactory results, doctors are in a position of having to apply instruments of scientific precision such as the laboratory, the X-ray, the skilled services of nurses and dieticians. It is manifestly evident that this cannot be accomplished in a home and, therefore, there has been developed a system of clinics and hospitals throughout the land. To these institutions are brought an enormous number of so-called charity cases. There those who minister to their needs are aware of the fact that the so-called charity patient is helpless in bed, is utterly dependent, cannot employ and discharge because of lack of funds, nor can he raise his hand in self-defense. Doctors recognize this peculiar plight of a large group of patients, are inclined to do for him in a manner not peculiar to the care of the so-called "charity patient." The charity patient is, as a rule, not under the care of a single physician. To his bedside there may be called a group of doctors, among them one or more of the so-called "specialists" who, because of his peculiar opportunity, has been able to develop a scientific skill along highly specialized lines. Thus, the charity patient has applied to his cure the wealth of the life experiences of the hospital force and equipment which has been created for this use.

With the more highly standardized methods of medical education, all physicians are given more or less the same degree of training and collegiate instruction. Upon entering professional life there develops a tendency toward peculiar efficiency in certain phases of medicine or surgery. Broadly speaking, the doctor of today in the most remote rural district is potentially as competent as the physician in the city. Unfortunately, only in the urban centers has it been possible to place in the hands of the doctors, incompletely thus far, the instruments with which to work, namely, hospitals and personnel and their equipment.

The State of Florida is composed of a group of counties more or less rural in coloring. More than 60% of the counties in Florida are devoid of hospital facilities. As a matter of financial defense it has thus far been impossible for the municipally or county-supported hospitals in the different sections of the state to provide finances for the care of those who come from without their respective geographical boundaries, much as they would like to do so. Thus far, in the history of the great commonwealth of Florida, the charity program of the state has consisted very largely of the establishment of the State Hospital for Insane, its School for Deaf and Blind and its Colony for Epileptics and Feebleminded. In its State Hospital for the Insane, which is located in a rural district, far from the center of population of the state, may be found a patient population of over 3,000 charity, mental cases. Institutional experience has taught unerringly that when the patient population of an institution reaches 3,000, the operation of the hospital becomes cumbersome and ineffective. Hospitals located nearer an urban center have the advantage of fire and police protection, available supplies, the constant scrutiny of citizens who have the institution at heart, and the gratuitous services of doctors and lay people interested in problems of public welfare.

A legislature some time in the past made provision for the establishment of a state hospital for the tuberculous. For some reason or other, the institution has never been developed. A feeble effort has been made to care for the crippled children of the state. A doctor working alone, with very limited finances and inadequate personal compensation, has done a monumental work, so far as his energy would permit under existing conditions, of hospitalizing cancer cases in private contract hospitals.

Statistics available in the Bureau of Vital Statistics of the State Board of Health will doubtless

reveal a number of annual deaths from cancer. The early treatment of cancer is usually surgical. When surgery has failed or been neglected, the use of radium and powerful, deep X-ray equipment has been the means of saving human lives. The life earnings of an average individual would not purchase enough radium to adequately treat, with heavy dosage of radium, the average case of cancer.

Within the confines of the State of Florida there are doubtless many who are groping around blind and helpless. Most states have developed a program whereby these unfortunates are aided, their condition brought to the attention of expert physicians and in many, many instances the reward has been the restoration of vision, the loss of which is the greatest of all human calamities.

When one is committed to the State Hospital for Insane, he is deprived of his citizenship and forever after has attached to his name the odium of having been a lunatic. The Massachusetts General Hospital is a state hospital and is an institution in which modern medical and surgical results have been constantly achieved over a period of many years. The great Charity Hospital at New Orleans, Louisiana, is likewise a state institution wherein the lame and the halt and the blind may come in the hope of a cure. Mississippi has a state hospital for the general and surgical care of the indigent of the state. Florida has not even a system of almhouses and, because of this fact alone, many elderly people have been committed to the State Hospital for the Insane because there was no other place to which to send them.

Speaking, therefore, as the official voice of the Florida Medical Association, may I remind the listeners that it is the belief of all of the good doctors everywhere that the realization of having equipment, the constructive service for those who are helpless and cannot assist themselves, brings into the human heart the greatest degree of happiness that can come.

May the doctors of Florida on this occasion say to you that we labor always cheerfully in the care of those who are poor and helpless. The patient we term the "charity patient" is a most grateful individual and one who may in later years exert a tremendous influence in our civic affairs. The charity cases have not been a thorn in our sides, so to figuratively speak, but have been a joy and inspiration and a solace to us in our professional efforts. May we not, therefore, invite you, as the citizens of the great Commonwealth of Florida, to join hands with us in expanding this program by placing in our hands the instruments with which to work.

Might it not be a worth-while project to give favorable consideration to the establishment of a general hospital for the medical and surgical care of the poor of the state, where infant lives may be spared, where the lame and the blind and the cancerous may receive comfort, if not cure; an institution wherein the tuberculous may be nursed back into health and happiness and be sent back into their respective communities as living memorials, instructing other unfortunates in the method of living in the open air and sunshine and the means of curing tuberculosis, a disease which is 90-odd per cent curable if properly handled; an institution to which the crippled children of the state may be taken and there restored to normal physical activity and sent out ever grateful and thankful to a benevolent and far-seeing people who made it possible for them to go through life without the physical difficulties which, if uncured, would have made life's problems more or less gloomy and hopeless; an institution to which the insane may be sent in the acute phases of their disease and wherein 60% to 90% could be promptly cured because of medical service which would be available to them and which is not available in the present, crowded institution known as the State Hospital. If, after all physical defects among the acutely insane have been cured, and the patient then becomes chronically insane, he could be wisely transferred to the State Hospital at its present location and there, with proper living and eating and sleeping and isolation, might eventually get well.

In general, might I say that it is the policy of the doctor not to speak in an appreciatory manner of his charity work, but upon this occasion the message from the profession at large has as its purpose an invitation to you, as citizens of this great state, to join hands with us and to enable us to, more forcibly than we can now, allege that as doctors we cure occasionally, we relieve frequently, but surely we comfort always.

"Experience in dealing with many opinions makes the mind more flexible and confirms it in a final choice of the best course to take."—JOUBERT.

CORRESPONDENCE

The Journal is pleased that members of the Association are taking advantage of this column to express their individual views.

The ideas of our members and comments on letters published are solicited.

To the Editor:

HIGH COST OF MEDICAL SERVICE

Throughout the country the high cost of medical service has been a general topic of discussion, so much so that a committee was appointed by President Hoover to investigate the reason therefor, and its cure.

A simple study of cause and effect must make the cause and cure apparent. Although the cost of medical service was admittedly high, yet the investigation showed that the average earning of doctors in the United States was $2,400 per year, from which had to be deducted office expense, medical and surgical supplies, transportation expense, etc. His remuneration was for a twenty-four-hour duty, with actual service of probably twelve to sixteen hours. In the face of these facts no reasonable person could consider that the doctor was overpaid for his services. Then what reason could be given for a high cost of medical service if the doctor was not overpaid—it could only mean that those who were financially able and appreciative of a doctor's service, paid for those who had learned that they could get doctors' services without paying.

A doctor's services is his merchandise, the same as a suit of clothes is to a haberdasher or groceries to a grocer. If he furnished gratis his goods to the indigent he would have to charge all others a high price for his commodity — if he stayed in business, this making a high cost of clothing or groceries.

Whenever an indigent person is found in need of medical or surgical care the public comes to his rescue and saves his life by calling the doctor. If the doctor should suggest that he was willing to put his dollar, along with the public, to provide this service, feeling that the responsibility was not his entirely, he would seem unreasonable, but it would be perfectly reasonable if it was to provide a suit of clothes or groceries. If it were possible to reverse the order of things and consider that, as the saving of his life was the more important, medical service should be provided for while the merchant and groceryman be expected to furnish food and clothing gratis, we would then have a high cost of food and clothing and not medical service (that is if the merchant and grocer stayed in business).

We feel that we are facing an unjust sense of both values and responsibility in regard to our services, yet feel that it is of our own making and it is up to us to produce the cure—that is if we are to stay in business. In the past we have offered our services, gratis, to every bona fide agency for doing charity; we have done it so long and so freely, that by our own acts have depreciated the value of our services.

This depreciation of the value of our services was made so apparent to us through the attitude of the Reconstruction Finance Corporation in their restrictions on the spending of money for public welfare, stating that this money could be used for every type of service except medical or surgical, and yet the same government ask: "Why the high cost of medical service?"

We of the medical profession are facing the possibility of state controlled practice of medicine—unless we ourselves find a just solution of our responsibility to the public. We feel that under state medicine the public would have a service without personal touch or interest. This mechanical service would be undeserving of the love and appreciation which the medical profession has received for its services from the public in the past.

This question has come up, under the stress of economic conditions along with a number of others like tax burdens. To distribute the load of responsibility more equitably, the recently adoption of resolutions* by the Seminole County Medical Society was a step forward.

The fact that doctors have carried this burden of responsibility in the past, when economic conditions were so that it could be carried, is no argument why they should not ask for a just and equitable distribution of this load under these stress conditions.

We are confident, although our resolutions may seem radical, that in taking this step we can begin working out a cure for the high cost of medical service by placing the responsibility of public welfare more equitably, so that those who pay for medical service do not have to pay for its entire upkeep.

(Signed) S. Puleston.

*Resolutions reproduced on p. 354.

MEMBERSHIP ROSTER
FLORIDA MEDICAL ASSOCIATION
CALENDAR YEAR 1932

ALACHUA COUNTY MEDICAL SOCIETY

Colson, J. H., President.....Gainesville
Hodges, James H., Vice-President,
234 E. Main St. Gainesville
Andrews, Edwin H.,
Sec'y-Treas. Gainesville
Dailey, I. A. Micanopy
Dell, J. Maxey,
333 W. Main St., So. ...Gainesville
DePass, Matthew H.,
E. University Ave. Gainesville
Elmore, W. T.,
Baird Bldg. Gainesville
Haskell, Lyman G.,
University of Florida ...Gainesville
King, Seeber Lake Butler
King, T. Byron,
332 W. University Ave., Gainesville
Lassiter, Wilhurn Gainesville
Maines, John E., Jr.,
331½ W. University Ave., Gainesville
Smith, Dewitt T.,
Tucker Bldg. Gainesville
Snow, Thomas A.,
103 E. University Ave., Gainesville
Summerlin, J. L.,
1 Baird Bldg. Gainesville
Summitt, R. E.,
335 W. University Ave., Gainesville
Thomas, W. C. Gainesville
Tillman, George C.,
431 W. University Ave., Gainesville
Weeks, L. R. Trenton
Whitaker, C. D. Raiford
Young, Wm. C. Chiefland

BAY COUNTY MEDICAL SOCIETY

Lee, W. J., Sec'y-Treas....Panama City
*Adams, Daniel M.,
505 5th St. Panama City
Blackshear, W. J. Panama City
Nixon, James M. Panama City
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Chunn, J. D. St. Cloud
Creel, W. J. Eau Gallie
Page, Walter C.,
317 Delannoy Ave.....Cocoa
Potthoff, E. W. Titusville
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Brown, Oliver C.,
Suite 411, 1st Natl. Bk.
Bldg. Ft. Lauderdale
Butler, Bruce F.,
206 Bank Bldg. Hollywood
Carter, Donald E.,
915 1st Nat. Bk. Bldg., Ft. Lauderdale
Hartley, James M.,
Central Arcade Hollywood
Hendricks, Elliott M.,
314 Sweet Bldg. Ft. Lauderdale
Hodges, John W.,
Gralynn Hotel Miami
Johnston, John A.,
201 Bryan Court Ft. Lauderdale
Kinsey, E. T.,
802 Prof. Bldg. Miami
Lingeman, Ralph B.,
915 1st Nat. Bk. Bldg., Ft. Lauderdale
McClellan, Geo. S. Pompano
McLaury, Elhert,
214-220 1st Nat. Bk. Bldg., Hollywood
Peavy, Henry J.,
505 1st Nat. Bk. Bldg., Ft. Lauderdale
Robinson, Leigh F.,
403 1st Nat. Bk. Bldg., Ft. Lauderdale
Roper, Luther E.,
2011 Hollywood Bldg.....Hollywood
Skiff, Francis S.,
303 1st Nat. Bk. Bldg., Ft. Lauderdale

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307 Ingraham Bldg. Miami
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Agos, I. H.,
410 Huntington Bldg. Miami
Allen, O. F.,
711 Huntington Bldg. Miami
Amerise, A. Daniel,
Coral Gables Clinic ...Coral Gables
Aronovitz, S.,
705 Huntington Bldg. Miami
Babcock, H. C.,
Calumet Bldg. Miami
Baker, Juel M.,
312-14 Seybold Bldg. Miami
Baker, L. A.,
570 W. Flagler St. Miami
Barfield, J. O.,
312 N. W. Third Ave.....Miami
Barge, H. A.,
414 Calumet Bldg. Miami
Barge, W. J.,
420-421 Calumet Bldg. Miami
Bertram, A. J.,
Blvd. Apts., 936 Biscayne Blvd., Miami
Bible, C. J.
1203 W. Flagler St. Miami
Black, Nelson M.,
703 Huntington Bldg. Miami
Boughton, Herman,
441 Washington Ave...Miami Beach
Bullard, C. P.,
2930 N. W. 8th Ave. Miami
Burch, R. N.,
2827 N. Miami Ave. Miami
Chambers, S. E.,
409 Huntington Bldg. Miami
Chandler, G. E.,
Huntington Bldg. Miami
Cleghorn, Chas. D.,
Suite 1109 Huntington Bldg., Miami
Conger, G. D.,
1600 N. W. 36th St. Miami
Coplan, M. M.,
601 Huntington Bldg. Miami
Courie, E. S.,
P. O. Box 265..(Lemon City) Miami
DeBoe, M. P.,
Box 505 Miami
Deederer, Carleton,
300 Ingraham Bldg. Miami
DeVore, Louise,
809 Huntington Bldg. Miami
Dobrin, Max,
168 S. E. First St. Miami
Dodge, Percy L.,
812 Huntington Bldg. Miami
Donald, Ernest,
305 Huntington Bldg. Miami
Dunaway, C. E.,
1209 Huntington Bldg. Miami
DuPuis, J. G.(Lemon City) Miami
Elder, S. F.,
Huntington Bldg. Miami
Elgin, L. W.,
508 Huntington Bldg. Miami
Ellis, W. H.,
15 N. E. 11th St. Miami
Faver, Robert M.,
127 N. E. 5th St. Miami
Fitzgerald, Willard L.,
504 Huntington Bldg. Miami
Flipse, M. J.,
305 Huntington Bldg. Miami
Fox, H. H.,
Box 592 Miami
Foxworthy, F. W.,
1009 Huntington Bldg. Miami
Freeman, Mary Perrine
Gammage, Tom R.,
227 N. E. 5th St. Miami
Ghertler, Max.,
1715 S. W. 11th St. Miami
Goodson, W. M.,
315 Olympia Bldg. Miami
Gowdy, F. A.,
409 Ingraham Bldg. Miami
Gowdy, R. A.,
925 Lincoln Road Miami Beach
Gowe, Donald F.,
N. E. 2nd Ave. and 36th St., Miami
Graves, J. R.,
709 Huntington Bldg. Miami
Grimes, D. H.,
Box 377 South Miami
Haggard, W. A.,
903 Security Bldg. Miami
Hall, E. J.,
201 Venetian Bldg. Miami
Hall, John E.,
Box 2722 Miami
Harris, D. W.,
403 Huntington Bldg. Miami
Harris, R. M.,
1001 Huntington Bldg. Miami
Hatch, E. B.,
71 N. E. 11th St. Miami
Heck, Maurice E.,
216 N. E. 2nd Ave. Miami
Hodsdon, B. F.,
418-20 Security Bldg. Miami
Hodsdon, L. A.,
418-20 Security Bldg. Miami
Holmes, A. G.,
414 N. E. 1st Ave. Miami
Holmes, R. J.,
601 Huntington Bldg. Miami
Hotchkiss, W. T.,
Aladdin Bldg. Miami Beach
Hutson, T. W.,
309 Huntington Bldg. Miami
Ingersoll, J. M.,
1700 S. Bayshore Lane Miami
Jeffrey, S. L.,
4022 Douglas Road Miami
Jenkins, L. M.,
712 Huntington Bldg. Miami
Jenkins, Paul K.,
Box 35 Miami Beach
Jones, Allan,
337 Lincoln Rd. Miami Beach
Jones, W. C., Jr.,
409 Calumet Bldg. Miami
Keeler, F. L.,
1106 Huntington Bldg. Miami
Keely, J.,
2307 N.E. 4th Ave., Chester
Apts. Miami
Kemp, A. J.,
207-10 Congress Bldg. Miami
Kennon, C. L.,
411-12 Huntington Bldg. ...Miami
Kirsch, M. D.,
408 Huntington Bldg. Miami

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336 Ingraham Bldg. Miami
Leavitt, H. A.,
127 N. E. 5th St. Miami
Lefholz, R.,
1009 Huntington Bldg. Miami
Lewis, Taylor,
302-4 Congress Bldg. Miami
Light, S. D. W.,
Calumet Bldg. Miami
Lithgow, Wm. D.,
245 N. E. 25th St. Miami
Litterer, Ammon B.,
603 Huntington Bldg. Miami
Lott, Young C.,
144 N. E. 2nd Ave. Miami
Lowe, Eugene C.,
258 N. E. 21st St. Miami
Lucinian, Joseph H.,
404 Huntington Bldg. Miami
Luke, J. M. J.,
Congress Bldg. Miami
Lustgarten, A.,
409 Olympia Bldg. Miami
Lyell, Robert O.,
305-10 Huntington Bldg.....Miami
MacDoncll, Geo. N.,
1112 Huntington Bldg. Miami
McGunagle, J. E.,
1885 W. Flagler St. Miami
McKenzie, E. N.,
336 Ingraham Bldg. Miami
McKibben, Wm. Watson,
316-318 Ingraham Bldg. Miami
Manson, Plumer J.,
Rosetta Theatre Bldg...Little River
Martin, M. C.,
548 W. Flagler St. Miami
Maxwell, E. B.,
610 Huntington Bldg. Miami
Maxwell, Leslie H.,
835 Lincoln Road Miami Beach
Medlin, Willard B.,
502 Security Bldg. Miami
Milton, J. D.,
905 Huntington Bldg. Miami
Morrow, Frank R.,
305 Huntington Bldg. Miami
Newell, C. E.,
21 S. W. 12th Ave. Miami
Nichol, E. Sterling,
305 Huntington Bldg. Miami
O'Quinn, Leon H. Hialeah
Otto, T. O.,
704 Huntington Bldg. Miami
Owens, Duncan,
337 Lincoln Rd. Miami Beach
Palmer, B. H.,
502 Huntington Bldg. Miami
Panettiere, Cayetano,
Aladdin Bldg. Miami Beach
Paulk, Geo.,
202 Venetian Bldg. Miami
Payne, J. W.,
203 Venetian Arcade Miami
Payton, Frazier J.,
Allison Hospital Miami Beach
Pearson, Homer L., Jr.,
1605 Biscayne Blvd. Miami
Pearson, John R.,
205 Bedford Bldg. Miami
Pearson, Nelson T.,
1109 Huntington Bldg. Miami
Pearson, Rufus J.,
306 Calumet Bldg. Miami
Perry, C. Larimore,
509 Huntington Bldg. Miami
Peters, Edgar,
506 Olympia Bldg. Miami
Phillips, Kenneth,
610 Huntington Bldg. Miami
Quillian, Warren,
Coral Gables Clinic...Coral Gables
Raap, Gerard,
908 Huntington Bldg. Miami
Repass, Robert E.,
337 Lincoln Road Miami Beach
Rogers, Hunter B.,
27 N. W. 12th Ave. Miami
Sayles, Charles F.,
311 N. W. 3rd St. Miami
Seeds, J. B.,
544 W. Flagler St. Miami
Shaw, E. Clay,
702 Huntington Bldg. Miami
Shisler, J. W.,
Director, Welfare Dept. Miami
Simpson, J. R.,
614 Huntington Bldg. Miami
Sinclair, J. A. B.,
264 N. E. 20th St. Miami
Skaggs, P. T.,
510 1st Natl. Bank Bldg.....Miami
Smith, C. Kirby,
210 E. Flagler St. Miami
Smith, J. A. Homestead
Smith, J. W.,
1661 W. Flagler St. Miami
Smith, M.,
405-6 Huntington Bldg.....Miami
Snyder, John Wm.,
402 Huntington Bldg. Miami
Stewart, J. S.,
1605 Biscayne Blvd. Miami
Stuart, J. D.,
227 N. E. 5th St. Miami
Tallunan, Maurice H.,
1401 Huntington Bldg. Miami
Thomas, Edwin C.,
46 N. E. 5th St. Miami
Thomas, Kelly C.,
318 N. W. 1st St. Miami
Thomas, Merriek D.,
211 Sixth St. Miami Beach
Thorne, James I.,
Hotel Enrope Athens, Greece
Threlkeld, Major E.,
205 Calumet Bldg. Miami
Tower, John B.,
32 No. Krome Ave. Homestead
Tumlin, Corhett Edward,
315 Olympia Bldg. Miami
Turner, J. C.,
Tatum Bldg. Miami
Vinson, Willie J.,
400 Ingraham Bldg. Miami
Vogt, Ferdinand A.,
207 Calumet Bldg. Miami
Walker, Harrison A.,
704 Lincoln Road Miami Beach
Walters, Arthur L.,
337 Lincoln Road Miami Beach
Watters, W. H.,
Boston-Miami Clinic,
P. O. Drawer II Coconut Grove
Weiland, A. H.,
227 Aragon Ave. Coral Gables
Weinkle, Barney,
512 Olympia Bldg. Miami
Westermann, Julius T.,
Box 1542, Buena Vista Sta., Miami
White, David W.,
337 Lincoln Road Miami Beach
Whitten, Benjamin Leland,
Box 505 Miami
Wilson, M. C.,
809 Huntington Bldg. Miami
Withers, G. H.,
Aladdin Medieal Arts
Bldg. Miami Beach
Wood, Arthur W.,
401 Security Bldg. Miami
Woodard, Robert C.,
Jackson Memorial Hospital, Miami
Wright, Sheffel,
60 N. E. 46th St. Miami
Youmans, Corren P.,
701 Prof. Bldg. Miami
Youmans, I. C.,
Prof. Bldg. Miami

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Kirkpatrick, Chas. H.,
Box 454 Arcadia
*McSwain, D. L. Arcadia
Poueher, Allen A. Wauchula
Pyatt, Wesley S. Bowling Green
Simmons, John A. Areadia
Simmons, S. J., Jr. Clewiston
Spears, Ben D. Wauchula
Weems, Howard V.,
22 Oak St. Sebring

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2017 Main St. Jacksonville
Adams, Thos. S.,
612 Lynch Bldg. Jacksonville
Alford, Neil,
St. James Bldg. Jacksonville
Arms, B. L.,
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Bacon, Henry,
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Baker, R. M.,
Professional Bldg. Jacksonville
Barfield, Frederick G.,
St. James Bldg. Jacksonville
Baumgartner, Carl J.,
406 Masonic Bldg. Jacksonville
Beckman, Geo. E.,
Professional Bldg. Jacksonville
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St. James Bldg. Jacksonville
Blackmar, Ray Wellborn,
320-321 St. James Bldg..Jacksonville
Blitch, Clifford G.,
355 St. James Bldg. ...Jacksonville
Boone, James L.,
500 Professional Bldg...Jacksonville
Boyd, John E.,
342 St. James Bldg. ...Jacksonville
Bransford, L. E.,
Prof. Bldg. Jacksonville
Brillhart, H. L.,
Graham Bldg. Jacksonville
Brink, F. A.,
Box 4479 Jacksonville
Brinson, P. A. Baldwin
Brinson, W. D. Baldwin
Broadbent, Oliver P.,
1022 Park St. Jacksonville
Brown, Alan DeWitt,
417 St. James Bldg. ...Jacksonville
Bryant, James Malone,
303 Medical Arts Bldg. Jacksonville
Buckman, Thos. E.,
1022 Park St. Jacksonville
Carefoot, E. I.,
Prof. Bldg. Jacksonville
Cason, T. Z.,
2033 Riverside Ave. Jacksonville
Chapman, Benjamin A.
2151 Pearl St. Jacksonville
Chilli, Joseph L.,
318 St. James Bldg. ...Jacksonville
Collins, C. C.,
St. James Bldg. Jacksonville
Copp, F. A.,
458 St. James Bldg. Jacksonville
Counts, H. W.,
215 Professional Bldg...Jacksonville
Croft, Theo. Gaillard,
St. James Bldg. Jacksonville
Cunningham, Lester W.,
St. James Bldg. Jacksonville
Day, Gaston,
St. James Bldg. Jacksonville
Dean, Russell,
St. James Bldg. Jacksonville
Drew, Horace R.,
St. James Bldg. Jacksonville
Driskell, Simon E.,
St. James Bldg. Jacksonville
Dyrenforth, Lucien Y.,
413 Medical Arts Bldg., Jacksonville
Eaton, Paul,
State Board of Health, Jacksonville
Enneis, F. B.,
Professional Bldg. Jacksonville
Erwin, Stanley,
1001 Lynch Bldg. Jacksonville
Field, Thomas S.,
712 Laura St. Jacksonville
Gammon, Julian E.,
700 Professional Bldg., Jacksonville
Goodale, Banks H.,
St. James Bldg. Jacksonville
Greene, Ralph N.,
Medical Arts Bldg. ...Jacksonville
Gwinn, Van H.,
2585 Riverside Ave.....Jacksonville
Hanson, Henry,
State Board of Health
Bldg. Jacksonville
Harris, Herrman H.,
608 Greenleaf & Crosby
Bldg. Jacksonville
Harris, W. G.,
St. James Bldg. Jacksonville
Hartman, James H.,
546 Lomax St. Jacksonville
Harwell, D. F.,
209 Peninsular Cas.
Bldg. Jacksonville
Hayes, J. W.,
309 Professional Bldg...Jacksonville
*Heggie, N. M.,
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Henley, Chas. F.,
2151 Pearl St. Jacksonville

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Medical Arts Bldg. ...Jacksonville
Holloway, Luther W.,
359 St. James Bldg. ...Jacksonville
Horne, Hendley F.,
325 W. Duval St. Jacksonville
Humphreys, David G. Fernandina
Ira, Gordon H.,
452 St. James Bldg. Jacksonville
Jelks, Edward,
Riverside Hospital Jacksonville
Jennings, C. L.,
Medical Arts Bldg. Jacksonville
Johnston, Crowell W.,
355 St. James Bldg. ...Jacksonville
Keisling, Frederick C.,
315 Professional Bldg., Jacksonville
Killinger, Raymond R.,
St. James Bldg. Jacksonville
Kirby-Smith, Joseph Lee,
511-15 Greenleaf & Crosby
Bldg. Jacksonville
Kirk, Wm. W.,
608 Greenleaf & Crosby
Bldg. Jacksonville
Knauer, W. J.,
Buckman Bldg. Jacksonville
Knight, A. Comer,
Professional Bldg. Jacksonville
Krueger, Frederick W.,
452 St. James Bldg.....Jacksonville
Limbaugh, Louie M.,
458 St. James Bldg.....Jacksonville
McDowell, Walter,
1016 First Ave.....Evansville, Ind.
McEuen, H. Bernard,
320 Professional Bldg., Jacksonville
McGinnis, Robt. H.,
2063 Oak St. Jacksonville
McKenzie, Albert C.,
St. James Bldg. Jacksonville
McLeod, R. F.,
Masonic Bldg. Titusville
Mabry, C. B.,
St. James Bldg.....Jacksonville
Manhoff, Ben,
712 Laura St. Jacksonville
Manning, Wm. S.,
St. James Bldg. Jacksonville
Martin, P. H.,
Professional Bldg.....Jacksonville
May, Robt. D.,
302-5 Professional Bldg.
..... Jacksonville
Milam, Ernest B.,
Medical Arts Bldg. ...Jacksonville
Mitchell, Geo. M.,
712 Laura St. Jacksonville
Mitchell, John H.,
300 Professional Bldg..Jacksonville
Moe, Leonard N.,
212 St. James Bldg....Jacksonville
Morris, S. A.,
237 W. Duval St. Jacksonville
Norris, Samuel R.,
Medical Arts Bldg. ...Jacksonville
Norwood, J. K.,
211 St. James Bldg. Jacksonville
Oberdorfer. Aaron Z.,
1830 Mallory St. Jacksonville
Oetjen, G. F.,
211 E. Forsyth St., ...Jacksonville
Owens, J. H.,
452 St. James Bldg.....Jacksonville
Page, W. Grady,
111 W. Adams St. Jacksonville
Palmer, Thomas M.,
2063 Oak St. Jacksonville
Parramore, James B.,
401 St. James Bldg.....Jacksonville
Pasco, J. D.,
Medical Arts Bldg. ...Jacksonville
Peyton, Harry A.,
2033 Riverside Ave. ...Jacksonville
Porter, H. W.,
340 St. James Bldg.....Jacksonville
Ramage, Raymond B.,
219-20 Professional Bldg.....
..... Jacksonville
Randolph, J. H.,
St. James Bldg. Jacksonville
Richards, Ferdinand,
Professional Bldg. Jacksonville
Richardson, George W.,
343 St. James Bldg.....Jacksonville
Richardson, Shaler,
111 W. Adams St. Jacksonville
Roberts, Earl,
200 Prof. Bldg. Jacksonville
Rogers, W. W.,
Professional Bldg. Jacksonville
Ross, Wm. E.,
St. James Bldg. Jacksonville
Royce, Clayton E.,
Medical Arts Bldg.....Jacksonville
Sample, A. M., Jr.,
Riverside Hospital Jacksonville
Sandusky, C. M.,
28 W. Monroe St. Jacksonville
Schneider, David,
Greenleaf & Crosby Bldg.....
..... Jacksonville
Schnauss, Wm. R.,
312 Hildebrandt Bldg., Jacksonville
Sellers, E. T.,
412-413 St. James Bldg.
..... Jacksonville
Sengstak, Ernst P. E. Mandarin
Shaw, W. M.,
St. James Bldg. Jacksonville
Simpson, J. Knox,
712 Laura St. Jacksonville
*Smith, Ralph E.,
211 E. Forsyth St. Jacksonville
Stinson, W. M.,
1611 Aberdeen St.....Jacksonville
Stollenwerck, A. D.,
25 W. Beaver St. Jacksonville
Taylor, H. Marshall,
111 W. Adams St. Jacksonville
Teeter, Edmund H.,
305 St. James Bldg....Jacksonville
Thomas, Robt. Y. H.,
502-6 Lynch Bldg. Jacksonville
Thompson, David C.,
2579 Herschell St. Jacksonville
Thompson, T. C.,
318 Hildebrandt Bldg., Jacksonville
Tyler, Lockland V.,
San Marco Square, So. Jacksonville
Upchurch, Noble Alvin,
City Board of Health, Jacksonville
Van Schaick, Harold D.,
210 St. James Bldg.....Jacksonville
Veal, Ernest W.,
128 St. Johns Ave., So. Jacksonville
Waas, F. J.,
Professional Bldg.....Jacksonville
Washburn, Clayton D.,
St. James Bldg.....Jacksonville
Wilcox, Clarence R.,
712 Laura St. Jacksonville
Wilkinson, Albert H.,
313 Professional Bldg., Jacksonville
Wilson, Alpheus K.,
334 St. James Bldg.....Jacksonville
Wilson, J. F.,
310-12 Greenleaf & Crosby Bldg.,
..... Jacksonville
Woolsey, Bertram F.,
320 St. James Bldg.....Jacksonville
Wynn, Robt. S.,
305 Consolidated Bldg.,
W. Bay St. Jacksonville

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Hoffman, James M.,
Sec'y-Treas.,
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Ames, Allen M.,
206 Blount Bldg. Pensacola
Bell, John D.,
305 Blount Bldg.....Pensacola
Bickerstaff, James H.,
Blount Bldg Pensacola
Blackshear, T. E.,
Rooms 406-7-8,
American Natl. Bk. Bldg., Pensacola
Bryans, H. L.,
21½ E. Wright St. Pensacola
D'Alemberte, Clinton W.,
302 American Natl. Bk. Bldg.
..... Pensacola
Daniels, J. P.,
313 Brent Bldg. Pensacola
Gachet, Necy L., ...Century
Haisfield, Abram R.,
311 Blount Bldg Pensacola
Haisfield, H. B.,
311 Blount Bldg. Pensacola
Heinberg, Chas. J. Pensacola
Hixon, F. P.,
Blount Bldg. Pensacola
Holley, John C. Milton
Kennedy, S. G.,
511-12 American Natl. Bank
Bldg. Pensacola
Lischkoff, Mozart A.,
Blount Bldg. Pensacola
McGuire, J. J.,
Pensacola Hospital.....Pensacola
McMillan, D. W. Pensacola
Mock, A. E.,
314 Blount Bldg. Pensacola
Nobles, R. G.,
Blount Bldg. Pensacola
Nobles, V. R.,
Blount Bldg. Pensacola
Nohles, W. D. Pensacola
Payne, W. C.,
Blount Bldg. Pensacola
Pierpont, Juriah Harris,
511 American Bank Bldg..Pensacola
Quina, M. E. Pensacola
Renshaw, F. G.,
104 S. Palafox St. Pensacola
†Simpson, Horace L.,
20 W. Belmont Pensacola
Stokes, Thos. H.,
Theisen Bldg. Pensacola
Sullivay, Rosa L.,
1016 W. Chase St. Pensacola
Thames, Rufus Milton
Turberville, J. I. Century
Turberville, John S. Century
Turner, John B. Bagdad
Webb, Carol C.,
Blount Bldg. Pensacola

HILLSBORO COUNTY MEDICAL SOCIETY

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805 Citizens Bank Bldg.....Tampa
Gilmer, Eugene S., Vice-President,
Room 416, Citizens Bank Bldg.
..... Tampa
Cowart, James T., Sec'y-Treas.,
906 So. Rome Tampa
Adamson, Wm. P.,
610 Citizens Bank Bldg.....Tampa
Allen, Bundy,
302 Citizens Bank Bldg.....Tampa
Alsobrook, John W.,
120 N. Collins St.....Plant City
Anderson, Claude,
Citizens Bank Bldg Tampa
Andrews, Chadbourne A.,
715 Citizens Bank Bldg.....Tampa
Baldwin, R. E.,
Tampa Municipal Hospital..Tampa
Bartlett, Chas. W.,
Box 5512 Tampa
Beyer, A. R.,
Box 527 Tampa
Bidwell, Alfred Morrell,
401 1st Natl. Bank Bldg.....Tampa
Bitzer, Emory W.,
815 Citizens Bank Bldg.....Tampa
Black, Robert C.,
101 San Ever St. Plant City
Blackmon, H. J.,
Citizens Bank Bldg. Tampa
Blake, W. C.,
412 Citizens Bank Bldg.....Tampa
Boling, John R.,
1207-11 1st Natl. Bank Bldg.
..... Tampa
Bottari, Giulio C.,
1829½ Seventh Ave. Tampa
Brown, Harold O.,
215 Madison St. Tampa
Butchart, T. R.,
804 Grand Central Ave.....Tampa
Chandler, J. C.,
410 Citrus Exchange Bldg....Tampa
Christian, Geo. R.,
604 E. Lafayette St. Tampa
Cook, Geo. L.,
906 So. Rome Ave. Tampa
Costa, Frank J.,
care Centro Asturiano Hospital
..... Tampa
Dickinson, Joshua C.,
302 Citizens Bank Bldg.....Tampa
Draper, Arthur D.,
5607 Florida Ave. Tampa
Duke, Roncie R.,
708 Citizens Bank Bldg.....Tampa
Duncan, Wm. P.,
802 Tampa Theatre Bldg.....Tampa
Dyer, Walter H.,
1801½ 22nd St. Tampa
Efird, Lester J.,
Box 2519 Tampa
Ely, R. A.,
404½ Zack St. Tampa
Estes, J. L.,
815 1st Natl. Bank Bldg.....Tampa
Etheredge, S. H.,
706 Franklin St. Tampa

* Deceased. † Honorary Member.

Evans, Harry C.,
215 Madison St. Tampa
Forbes, Sherman B.,
409 Citizens Bank Bldg.....Tampa
Garcia, Parsons M.,
Box 7224 W. Tampa
Gilbert, Elsie,
6508 Central Ave. Tampa
Golden, Harold M.,
30 No. Michigan Ave...Chicago, Ill.
Grable, James S.,
706 Franklin St. Tampa
Grantham, James M.,
442 Lafayette Arcade.....Tampa
Hardy, G. E. W.,
818 First Natl. Bank Bldg., Tampa
*Helms, John S.,
Box 1439 Tampa
Helms, John S., Jr.,
Box 1439 Tampa
Henderson, R. P.,
612 Citizens Bank Bldg.....Tampa
Higgins, Allen F.,
330 Lafayette Arcade Tampa
Hopkins, C. D.,
1818 Hills Ave. Tampa
Jenson, Henry J.,
7303 Nebraska Ave. Tampa
Knauf, A. R.,
717 Citizens Bank Bldg.....Tampa
Knight, John C.,
121 No. Collins St. Plant City
Lancaster, Wm. J.,
Box 3010 Tampa
Lassman, Geo. A.,
21 Bennett Ave....New York, N. Y.
Lowry, Blackburn W.,
408 Citrus Exchange Bldg., Tampa
McEachern, J. R.,
Box 2214 Tampa
McRae, E. H.,
402 Citrus Exchange Bldg...Tampa
Maguire, Thomas C.,
104 S. Collins St.....Plant City
Maner, Geo. R.,
5111 Central Ave.....Tampa
Marney, Charles R.,
242 Lafayette Arcade.....Tampa
Martin, Douglas Dickinson,
906 So. Rome Ave. Tampa
Martorell, Abelardo,
Citizens Bank Bldg.....Tampa
Mills, Herbert R.,
706 Franklin St. Tampa
Mills, John Herman,
907 17th Ave. Tampa
Minardi, Joseph A.,
2203½ Seventh Ave. Tampa
Mitchell, L. B.,
Box 1020 Tampa
Moore, John T.,
3922½ Nebraska Ave. Tampa
Nelson, Robert G.,
712 Citizens Bank Bldg., ...Tampa
†Oppenheimer, Louis S.,
408 Citizens Bank Bldg.....Tampa
Ortega, Rafael,
Box 5513, Ybor Sta. Tampa
Patterson, Wm.,
312 Citrus Exchange Bldg...Tampa
Pearson, R. J.,
Rt. 1, Box 186.....Tampa
Rankin, Grover C.,
Box 1313 Tampa
Rowlett, W. M.,
Box 786 Tampa
Rudisill, C. A.,
Room 712, Citizens Bank Bldg.
..... Tampa
Saxton, J. J.,
315 Citrus Exchange Bldg...Tampa
Scuderi, S. A.,
230 S. Flower St., Los Angeles, Calif.
Shaver, E. F.,
1801½ 22nd St. Tampa
Smith, H. Mason,
903 Tampa Theatre Bldg....Tampa
Smoak, Edw.,
315 Citizens Bank Bldg.....Tampa
Spengler, Nathaniel L.,
903 Tampa Theatre Bldg....Tampa
Spoto, Joseph S.,
1829½ Seventh Ave. Tampa
Stone, Alvord L.,
102 E. Hillsboro Ave. Tampa
Stringer, Sheldon,
P. O. Box 105 Tampa
Taylor, Joseph W.,
706 Franklin St. Tampa
Torbett, R. S.,
409 1st Nat. Bank Bldg.....Tampa
Truelsen, Thomas,
Room 605, 706 Franklin St., Tampa
Vinson, J. C.,
215 Madison St., Box 724....Tampa
Weekley, Augustine S.,
325 Lafayette Arcade.....Tampa

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Baltzell, N. A. Marianna
Bertrem, J. Willie Greenwood
*Box, Wilmer C. Graceville
Dowling, J. B. Alliance
Finlay, David H. Blountstown
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Conklin, Raymond C.,
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Coupland, James D. Eustis
DeVane, W. G. Groveland
Fenn, Harry T. Mt. Dora
Hannum, M. M. Eustis
Hawkins, A. S.,
779 Montrose St. Clermont
Holland, Howard G.,
Suite 202, State Bk. Bldg., Leesburg
Lodor, Charles H.,
Palm Pharmacy Bldg.....Eustis
Morrison, Harry K.,
111 4th St., South.....Leesburg
Oetjen, Leroy H.,
Masonic Bldg Leesburg
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201 Pythian Bldg.,
Hendry St. Ft. Myers
Grace, Wm. H.,
Earnhardt Bldg. Ft. Myers
Harrison, Warren A.,
Pythian Bldg. Ft. Myers
Johnson, M. F. Ft. Myers
Jones, J. William Ft. Myers
Longbrake, Guy A.,
308 2nd St. Ft. Myers
Merrick, C. Gordon,
26 Leon Bldg. Ft. Myers
Newton, Robley D.,
11-12 Leon Bldg. Ft. Myers

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Barnes, Benjamin F. River Junction
Brevard, Ephraim M.,
Lively Corner Tallahassee
Brinson, John B., Jr.,
Dogwood St. Monticello
Cobb, Alva Thos., Jr.,
Fla. State Hospital, Chattahoochee
Daves, F. E. Chattahoochee
Davis, Julius C.,
203-8 Masonic Bldg.....Quincy
Dozier, L. L. Tallahassee
Godard, Robt F.,
Key Bldg. Quincy
Gwynn, Geo. H., Jr.,
Telephone Bldg.....Tallahassee
Johnston, John K.,
Exchange Bank Bldg., Tallahassee
McClure, Herbert A.,
care State Board of Health Bldg.
..... Tallahassee
Massey, Wm. W.,
Davidson Bldg. Quincy
Miles, W. G. Chattahoochee
Mols, Edith P.,
Florida State College...Tallahassee
Moor, Frederick C.,
Telephone Bldg. Tallahassee
Murrow, J. S. Appalachicola
Palmer, Henry E.,
408 South Adams St.....Tallahassee
Pound, J. H. Chattahoochee
Rhodes, Bricey M.,
121 E. College Ave.....Tallahassee
Watson, Francis Marion.....Chipley
Wilensky, M. C.,
Fla. State Hospital, Chattahoochee
Wilhoit, Sterling E. Quincy
Wilkinson, B. A.,
Telephone Bldg. Tallahassee
Williams, J. F. Monticello
Williams, John L. Tallahassee

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Blake, Lowrie W. Bradenton
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Clark, George T. Bradenton
Floyd, A. J. Palmetto
Harrison, M. M. Bradenton
Hollingsworth, Samuel G.,
451 12th St. Bradenton
Lancaster, B. M. Manatee
Larrabee, Chas. Wm.,
Larrabee Hospital Bradenton
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Cammack, K. R. Gulf Hammock
Chalker, James L.,
Masters Bldg. Ocala
Dozier, Henry C.,
9 No. Magnolia St. Ocala
Ferguson, R. D.,
Box 802 Ocala
Freeman, Albert H.,
Holder Block Ocala
†Hood, J. W. Ocala
Lane, W. K. Ocala
Lindner, E. G. Ocala
Lisk, Percy F. Ft. McCoy
Moore, J. N.,
210-12 Professional Bldg....Ocala
Peek, Eugene G.,
Commercial Bk. & Tr. Bldg., Ocala
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Pintado, Nilo C., Vice-President,
330 Duval St. Key West
Warren, Wm. R., Sec'y-Treas.,
511 Eaton St. Key West
Plummer, Geo.,
504 Simonton St. Key West

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209-212 Exchange Bldg. ..Orlando
Andrews, Laurin L.,
P. O. Box 1100 Orlando
Andrews, Mitchell M.,
Box 1817 Orlando
Ashley, K. C.,
1665 Florence Los Angeles, Cal.
Beardall, Harold M.,
147 E. Church St. Orlando
Brinson, H. Kissimmee
Burks, B. Auxford,
108 E. Park Ave. Winter Park
Butler, Paul T.,
23 Autrey Arcade Orlando

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Chappell, John R.,
Box 1370 Orlando
Chiles, J. H.,
Box 943 Orlando
Christ, Calvin D.,
Box 1137 Orlando
Coffin, C. E.,
336 Interlaehen Ave., Winter Park
Day, Horace A.,
209-212 Exehange Bldg.....Orlando
Dodds, Wm. H.,
11th St. and Penn. Ave., St. Cloud
Edwards, Gaston H.,
106-110 E. Central Ave.....Orlando
Folsom, Spencer A.,
11 Lucerne Circle Orlando
Gardner, J. F. Winter Park
Geiger, Hugh S.,
24½ Broadway Kissimmee
Gray, Frank D.,
311-12 Exehange Bldg.....Orlando
Gwynn, Humphrey W.,
Clinic Bldg. Orlando
Harms, F. H.,
40 N. Orange St. Orlando
Hoffmann, Carl D.,
25-27 Autrey Arcade Orlando
Hotard, Roland F.,
226 E. Park Ave. Winter Park
Ingram, L. C.,
Box 1711 Orlando
†Johnston, Colonel Geo. C.,
Box 272 Orlando
Lawrence, E. J. Winter Garden
Lawson, Ben H. Winter Garden
Lewis, P. M.,
Box 346 Orlando
McBride, Thomas E. Apopka
McEwan, Duncan T.,
106-110 E. Central Ave.....Orlando
McEwan, John S.,
106-110 E. Central Ave.....Orlando
Mallory, Meredith,
Box 1011 Orlando
Marshall, C. J.,
Exchange Bldg. Orlando
Morton, B. Rosalie Slaughter,
..... Winter Park
Neal, Thomas A.,
Box 321 Orlando
Oertel, H. B.,
32 E. Concord Ave. Orlando
†Person, W. C.,
258 So. Main St. Orlando
Pines, John A.,
106-110 E. Central Ave.....Orlando
Redding, John L.,
126 S. Orange St. Orlando
Rivers, Thomas M. Kissimmee
Shoemaker, Samuel A.,
30 E. Church St. Orlando
Sinclair, W. E.,
Clinic Bldg. Orlando
Spiers, Wm. H.,
Box 1712 Orlando
Sutter, Leroy M.,
Orlando-Fla. Sanitarium...Orlando
White, Roland T.,
211 S. Rosalind Ave. Orlando

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315 Comeau Bldg. ..W. Palm Beach
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Good Samaritan Hospital W. Palm Beach
Herpel, Frederiek K., Treasurer,
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Arnold, Wilbur O.,
Box 1735 W. Palm Beach
Baldwin, R. Henry,
1101 Harvey Bldg. ..W. Palm Beach
Binkley, John F.,
1206 Harvey Bldg...W. Palm Beach
Blair, Wm. M.,
424 Comeau Bldg. ..W. Palm Beach
Brantley, Grady H.,
P. O. Box 336 Lake Worth
Clay, B. S.,
1203 Harvey Bldg. ..W. Palm Beach
Cooley, Roy O.,
Box 1735 W. Palm Beach
Creel, Chas. E. Pahokee
Dawson, Geo. Millard,
P. O. Box 1836.....W. Palm Beach
Denison, Raymond C.,
521 Lake Ave. Lake Worth
Fleming, Samuel W.,
417 Harvey Bldg....W. Palm Beach
George, Wm. W.,
1116 Harvey Bldg. ..W. Palm Beach
Gerlach, Earl B.,
Gosman Bldg. W. Palm Beach
Gill, Richard S.,
1114 Florida Ave...W. Palm Beach
Gunter, T. D.,
Box 85 W. Palm Beach
Heath, Guy W.,
409-11 Harvey Bldg., W. Palm Beach
Lewis, Gaylord,
Harvey Bldg. W. Palm Beach
Nowling, James C.,
309 Harvey Bldg. ...W. Palm Beach
Papot, Grace E.,
811 Harvey Bldg. ...W. Palm Beach
Peek, Leon A.,
119 S. Narcissus St., W. Palm Beach
Peery, E. W.,
801 Harvey Bldg. ...W. Palm Beach
Pittman, J. H.,
401 Guaranty Bldg., W. Palm Beach
Powell, J. A.,
Box 561 W. Palm Beach
Rowe, Alva Lake Worth
Rozier, Lauchlin M.,
411-414 Comeau Bldg., W. P. Beach
Sayad, Wm. Y.,
1215 Harvey Bldg. ..W. Palm Beach
Shackelford, C. W. W. Palm Beach
Shackelford, W. L. W. Palm Beach
Sory, B. B., Jr.,
Harvey Bldg. W. Palm Beach
Stone, Vale D.,
313 Monroe Drive ..W. Palm Beach
Warren, Hobart E.,
Phipps Plaza Palm Beach
Weems, Nat M. Boynton
Wilher, A. B. Palm Beach
Young, Wilburn C. Canal Point

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Cannon, Augustus B., Pres., Lacoochee
Dame, Leland H., Viee-Pres., Inverness
Furlow, L. T., V.-Pres.....Brooksville
Creekmore, Geo. R., Sec'y-Treas.,
112 N. Main St. Brooksville
Bradshaw, J. T. San Antonio
Coogler, A. C. Brooksville
Dame, Geo. A.,
241 Main St. Inverness
Hamblin, A. C. Valrico
Hudson, P. J. Crystal River
Jackson, Thos. Fred,
Box 241 Dade City
Mills, David A. Zephyrhills
Moon, William B. Crystal River
Sistrunk, Robt. D. Dade City

PINELLAS COUNTY MEDICAL SOCIETY

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Gable, Linwood M., 1st Vice-Pres.,
Power & Light Bldg., St Petersburg
Post, Wm. G., Jr., 2nd Vice-Pres.,
814-815 Power & Light Bldg. St. Petersburg
Mills, A. L., Seeretary,
814 1st Nat. Bk. Bldg., St. Petersburg
Miller, Geo. E., Treasurer,
Equitable Bldg. St. Petersburg
Albaugh, Andrew P. ...Tarpon Springs
Anderson, J. M.,
Fla. Power Bldg.....St. Petersburg
Anderson, Wm. Douglas,
Box 53 Largo
Bieker, Annette M.,
Power & Light Bldg., St. Petersburg
Black, M. Eldridge,
311 Coachman Bldg. Clearwater
Bucknell, Howard,
Biltmore Hotel Atlanta, Ga.
Burnette, Elmer W.,
1st Nat. Bank Bldg., Tarpon Springs
Cooper, J. H.,
1st Natl. Bk. Bldg., St. Petersburg
Cranford, J. F.,
512-14 First Natl. Bk. Bldg. St. Petersburg
Davis, W. M.,
342 1st Ave., North ...St. Petersburg
Dawson, S. A.,
870 7th Ave., North..St. Petersburg
Dickerson, Lueien B.,
Williamson Bldg. Clearwater
Echard, T. B.,
Fla. Natl. Bk. Bldg., St. Petersburg
Farber, Wm. P.,
807 Pow. & Lt. Bldg., St. Petersburg
Funk, Neil E.,
305 Fla. Natl. Bank Bldg. St. Petersburg
Gable, Nonie Wilson,
Health Dept.,
175 Fifth St., North, St. Petersburg
Gable, Nonie Worth,
706 Pow. & Lt. Bldg., St. Petersburg
Green, Thadeus H.,
1014-15 Equitable Bldg. St. Petershurg
Griffin, Thos. R.,
Power & Light Bldg., St. Petershurg
Groves, W. H. Clearwater
Harden, W. W.,
814 1st Nat. Bk. Bldg. St. Petersb'g
Hardenbergh, John A.,
401 Pow. & Lt. Bldg., St. Petersburg
Hebard, C. E.,
741 Fifth Ave., No., St. Petersburg
Heibner, Eugene A.,
Power & Light Bldg., St. Petersburg
Herring, John A.,
350 3rd Ave., North, St. Petersburg
Hooper, C. A.,
200 Fourth St., No., St. Petersburg
Horne, Lester W.,
Power & Light Bldg., St. Petersburg
Jennings, Frank S.,
149 2nd St., North, St. Petersburg
Kaufman, Frank E.,
Coachman Bldg. Clearwater
Knowlton, R. H.,
Power & Light Bldg., St. Petersburg
Kumm, F. F.,
427 40th Ave.,
N. E. Minneapolis, Minn.
Lambdin, L.,
Box 1805 St. Petersburg
Langley, Francis H.,
614 Times Bldg St. Petersburg
LeBreton, Prescott,
American Legion Hospital St. Petersburg
Leith, Richard Bliss,
201 Snell Bldg.....St. Petersburg
Lochner, G. M.,
406 Pow. & Lt. Bldg., St. Petersburg
Lustig, Emil,
500 7th Ave., No. ..St. Petersburg
McConnell, Whitman C.,
1005 Equitable Bldg., St. Petersburg
MacCordy, Earl C.,
1335 9th St., North, St. Petersburg
Marr, Norval M.,
812 Pow. & Lt. Bldg., St. Petersburg
Mease, John A., Jr.,
Virginia Ave.....Dunedin
Melville, Edmond J.,
335 Third Ave., No., St. Petersburg
Moeller, Maximilian W.,
1077 15th Ave., No., St. Petersburg
Morgan, William E.....Chicago
Murphy, Ralph D.,
Box 82 St. Petersburg
Nettles, Robbins,
402-5 Coachman Bldg....Clearwater
Nickle, Millen Alexander,
503-5 Coachman Bldg....Clearwater
O'Brien, Raymond K.,
E. 105 5th Ave., No., St. Petersburg
†Osgood, G. E.,
2804 4th St., So. St. Petersburg
Peabody, J. D.,
456 3rd St., North, St. Petersburg
Prather, B. T.,
1st Natl. Bk. Bldg., St. Petersburg
Putnam, Harry Lyman,
1027 17th Ave., No., St. Petersburg
Quicksall, J. Braden,
221 Taylor Arcade...St. Petersburg
Quicksall, Wm. E.,
222 Taylor Arcade...St. Petersburg
Remington, Alvah C.,
304 W. Ave.....Rochester, N. Y.
Roope, A. P.,
Power & Light Bldg., St. Petersburg
Roush, Franklin W.,
4689 Lakeview Ave., St. Petersburg
Rudolph, Councill C.,
512 Power Bldg.....St. Petersburg
Sackett, Harry R.,
Box 41, Station "A", St. Petersburg
Simcox, Lawrence,
235 4th Ave., North, St. Petersburg
Solomon, H. D.,
Power & Light Bldg., St. Petersburg
Strickland, Jesse A.,
712 Pow. & Lt. Bldg., St. Petersburg
Stuart, M. H.,
208 Equitable Bldg., St. Petersburg

* Deceased. † Honorary Member.

Timberlake, Gideon,
6th Fl., Times Bldg., St. Petersburg
Wade, Hugh W.,
512 Fla. Power Bldg., St. Petersburg
White, Benj. Lewis,
202 1st Natl. Bank
Bldg. St. Petersburg
Whitford, Grace Ruarc Ozona
Williams, Carl Alonzo,
Box 975 St. Petersburg
Winchester, Harold E.,
Box 448 Dunedin
Wood, Alvin J.,
801 1st Natl. Bank
Bldg. St. Petersburg
Wylie, Leroy A.,
210-213 Medical Arts
Bldg. St. Petersburg

POLK COUNTY MEDICAL SOCIETY

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Hughes, Roht. L., Vice-President,
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Alexander, Omer R.,
Room 25 & 26 Beymer
Bldg. Winter Haven
Besenbruch, Peter W.,
Orange St. Davenport
Bird, Donald P.,
Marble Arcade Lakeland
Boulware, James,
303 Marble Arcade Lakeland
Carefoot, G. H. Ft. Meade
Clark, Samuel A.,
802 Marble Arcade Bldg., Lakeland
Cline, R. L.,
P. O. Box 462 Lakeland
Cordes, Henry B., Jr.,
P. O. Box 84 Frostproof
Epling, Brady D. Lake Wales
Freeman, Grover C.,
P. O. Box 1202 Lakeland
Fuller, Henry Mulberry
Gilchrist, J. G.,
Box 744 Bartow
Griffin, J. D.,
203 Hartzell Lakeland
Gyland, Stephen P. Brewster
Horton, Waldo,
539 Ave. B, N. W. ...Winter Haven
Hurlburt, C. J. Bartow
Irons, F. E. Winter Haven
Koon, Alpheus C.,
513 W. Lemon Lakeland
Lester, John G.,
P. O. Box 548 Lakeland
Lindsey, Sherrod A. Ft. Meade
McMurray, E. R.,
655 Wilson Ave. Bartow
Martin, Emmett E.,
152 7th St. Haines City
Mootv, Ross Heflin Winter Haven
Murphy, C. H. Bartow
Murphy, H. K.,
Polk and Main Sts. Mulberry
Newman, Heber Peacock Bartow
Overstreet, Geo. C.,
Marble Arcade Lakeland
Pearce, C. C. Mulberry
Pennington, B. Y. Lake Wales
Ragsdale, Velpeau H.,
A. A. C. Co. Hospital.....Pierce
Richards, H. Mercer,
Box 72 Lakeland
Sample, Joseph R. Haines City
Shafer, W. W. Haines City
Sherman, Wm. E.,
716 W. Central Ave., Winter Haven
Simmons, Thomas G.,
Corlett Bldg. Auburndale
Simpson, W. T. Winter Haven
Smith, Samuel F.,
Box 628 Lakeland
Stetson, A. G. C.,
Sullivan Bldg. Lakeland
Sullivan, Raleigh R.,
1006 Marble Arcade Bldg., Lakeland
Tillis, W. L.,
502 Marble Arcade Bldg., Lakeland
Tinkler, B. R. Lake Wales
Vaughn, John W.,
Box 1021 Lakeland
Weed, Walter A.,
Morrell Memorial Hosp., Lakeland
Wilhoyte, Roy E. Lake Wales
Williams, E. L. Ft. Meade
Wilson, Cecil H. Bartow
Wilson, John F., Jr.,
P. O. Box 254 Lakeland

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Ford, Edward W., ...Crescent City
Miller, W. S. Palatka
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pital Panama City

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Bldg. St. Augustine
Britt, Reddin, Secretary,
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Potter, Geo. W., Treasurer,
East Coast Hospital..St. Augustine
Estes, Edgar S.,
Rms. 305-307-309 1st Natl.
Bank Bldg. St. Augustine
Fletcher, E. Gordon,
East Coast Hospital..St. Augustine
Grace, Chas. C.,
East Coast Hospital..St. Augustine
Irwin, J. M. St. Augustine
Lockwood, Vernon A.,
East Coast Hospital..St. Augustine
Stanton, Gordon Hastings
Walkup, A. Clark,
116 St. George St.....St. Augustine

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P. O. Box 942 Stuart
Boothe, R. C. Ft. Pierce
Clark, H. D.,
Ft. Pierce Bank & Trust
Bldg. Ft. Pierce
Claxton, W. A.,
State Board of Health, Jacksonville
Council, Melton D.,
Arcade Bldg. Ft. Pierce
Glidden, C. H. Ft. Pierce
Hardee, E. B. Vero Beach
Hardie, Grover C.,
134½ N. 2nd St. Ft. Pierce
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Patterson, John C., Sec'y-Treas.,
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Burgner, Blanche A. Sarasota
Halton, Jos.,
Pineapple Ave. Sarasota
Harris, J. E.,
224 Commercial Court Sarasota
Johnston, W. J.,
215 Commercial Court Sarasota
Kennedy, David R.,
1st Bank & Trust Bldg. ...Sarasota
Metzger, Frank C.,
916-17 Citizens Bank Bldg., Tampa
Morton, Arthur O.,
Commercial Court Sarasota
Myers, Nicholas P. Parrish
Taylor, T. W.,
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Wilson, Cullen B.,
1st Trust & Bank Bldg. Sarasota

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Tolar, Julian N., Vice-President,
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Denton, John T., Sec'y-Treas.,
Meisch Bldg. Sanford
Knox, A. W.,
Masonic Temple Sanford
Langley, W. T.,
Meisch Bldg. Sanford
Mitchell, Clifford M. Sanford
Park, Chas. Lanier,
515-516 1st Natl. Bk. Bldg., Sanford
Puleston, Samuel,
Brumley Puleston Bldg.....Sanford
Selman, G. S.,
Lake View Ave. Sanford
Smith, Henry D.,
108½ Park St. Sanford
Stevens, Ralph E.,
212 N. Park Ave. Sanford

SUMTER COUNTY MEDICAL SOCIETY

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Albritton, Andrew B. Wildwood
Wood, S. C. Leesburg

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Weeks, J. L., Sec'y-Treas. Perry
Baker, W. J. Foley
Bryan, W. H. Scanlon
Greene, Ralph J. Perry
Smith, Walton H. Y.,
County Health Officer Perry
Warren, Geo. H.,
Main St. Perry

VOLUSIA COUNTY MEDICAL SOCIETY

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Wells, J. Ralston, Vice-President,
Woolworth Bldg. ...Daytona Beach
Rutter, Joseph H., Sec'y-Treas.,
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Bohannon, Clyde C.,
154 1st Ave. Daytona Beach
Bouchelle, Louis B. New Smyrna
Brown, L. V. L. DeLand
Chandler, J. R.,
213 Orange Ave. Daytona Beach
Clemmer, Chas. A.,
Box 3236 Daytona Beach
Davis, C. W.,
231 Coates St. Daytona Beach
Davis, Geo. A.,
Dreka Bldg. DeLand
Davis, Joseph Brown,
Halifax Dist. Hosp., Daytona Beach
Dillard, T. H. DeLand
Doern, William Y.,
Box 5272 Daytona Beach
Esch, J. P.,
315 So. Penn. Dr., Daytona Beach
Fogarty, Joseph N.,
Bin 5 Daytona Beach
Forster, Davis,
326 So. Beach St.....Daytona Beach
Glatzau, L. W.,
Dreka Bldg. DeLand
Green, George M.,
102½ S. Beach Daytona Beach
Henry, H. W.,
205 State Bank Bldg., New Smyrna
Howe, Raymond,
Box 1582 Daytona Beach
Howe, Roy,
222 Volusia Ave. Daytona Beach
Johnson, Harry D.,
Box 1242 Daytona Beach
Merryday, Harry L. Daytona Beach
Miller, B. E.,
412 Canal St. New Smyrna
Miller, Harold E.,
412 Canal St. New Smyrna
Miller, R. L.,
258½ S. Beach St...Daytona Beach
Munson, Albert S.,
110 So. Blvd. DeLand
Myres, M. J.,
Room 5, P. O. Bldg., Daytona Beach
Pay, W. C.,
221 W. Rich Ave. DeLand
Rawlings, James E.,
221 Orange Ave.....Daytona Beach
Stern, Maximilian,
Dreka Bldg. DeLand
West, Hugh DeLand
White, J. Blake,
Ormond Beach Hotel, Ormond Beach

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

Spires, R. B., President, DeFuniak Spgs.
Webb, E. P., Vice-President,
City Pharmacy Crestview
Williams, A. G., Sec'y-Treas., Lakewood
Huggins, E. L. Freeport
McSween, J. C. DeFuniak Springs
Spires, W. G. Darlington
Stephens, S. E. Laurel Hill

INDIVIDUALS

†Anderson, Thomas S.,
P. O. Box 127 Live Oak
Paul, L. H.,
Box 256 Bonifay

* Deceased. † Honorary Member.

STATE NEWS ITEMS

Dr. Gerry R. Holden, Jacksonville, was one of the guest speakers at the annual banquet of the Hillsboro County Medical Society held January 17th at Tampa.

* * *

Dr. Herrman Harris of Jacksonville delivered an interesting address on "The Evolution of Medicine" before the local Exchange Club during a meeting held in January.

* * *

Dr. George Scott McKnight and family of Avon Park were recent visitors in Haines City.

* * *

Dr. W. C. Page of Cocoa was a guest of the Orange County Medical Society at its annual banquet held recently.

* * *

Dr. W. C. Blake of Tampa was a visitor in Arcadia the latter part of January.

* * *

Dr. A. J. Bertram of Miami was recently robbed of a considerable sum of money by two bandits, one of whom had previously telephoned him, asking that he come to a certain address to treat a patient. Nearing the appointed place, the bandits boarded his car.

* * *

Dr. L. T. Furlow was the honored guest at a dinner party given at the Tangerine Hotel, Brooksville, by his friends recently. The occasion was in the form of a farewell party as Dr. Furlow and family left soon thereafter for St. Louis where he will engage in surgical work.

* * *

Dr. Hewitt Johnston of Orlando was the principal speaker at a meeting of the Orange County Health Council held the latter part of January. He spoke on "Immunization."

* * *

Dr. and Mrs. W. Lee Ashton of Umatilla were recently dinner guests of Dr. and Mrs. H. G. Holland of Leesburg.

* * *

Dr. J. N. Fogarty of Daytona Beach was recently surprised in the dining room of the Ormond Hotel on the evening of January 25th and presented with a large birthday cake. Dr. Fogarty is house physician for the Hotel Ormond, Hotel Coquina and Hotel Clarendon.

* * *

Dr. and Mrs. J. Pitt Tomlinson of Lake Wales were recent visitors in Sebring.

Dr. and Mrs. Sherman Forbes of Tampa recently returned from an extensive trip to Europe. Sailing last September, they visited Germany, Czechoslovakia, Vienna, Hungary, Italy, Switzerland, Monaco and France. Dr. Forbes worked in the clinics of Vienna for three months.

* * *

The following has been received from the Orange County Medical Society:

"By virtue of action recently taken by the Orange County Medical Society, Dr. L. M. Sutter and Dr. L. L. Andrews, of the Florida Sanitarium, have been suspended by that organization indefinitely.

"These members were tried on January 11, 1933, for violation of Section 4, Article 1, Chapter 2 of the Principles of Medical Ethics and were found to be guilty."

* * *

Dr. T. H. Wallis of Ocala was recently elected president of the local Kiwanis Club.

* * *

Dr. F. K. Herpel of West Palm Beach was the principal speaker at a meeting of the Junior Chamber of Commerce in that city recently. Dr. Herpel discussed the use of the X-ray in medicine and in industrial work.

* * *

The many friends of Dr. W. C. Chowning of New Smyrna will be glad to learn that he is well on his way to recovery, following an illness of some two weeks.

* * *

Dr. Jack Halton, Sarasota, who is first vice-president of the Association, delighted a large audience recently at the First Presbyterian Church of that city, when he appeared as soloist. Among other selections, Dr. Halton sang a composition of his own to the melody of Hayden's "Nature's Adoration," which was very well received.

* * *

Dr. Ernest B. Milam, Jacksonville, who is Florida district Kiwanis governor-elect, conducted the installation of officers at Tallahassee on December 31st.

* * *

Dr. Charles L. Kennon was the principal speaker before the Shadowlawn P.-T. A. recently. He explained the difference between antitoxin, toxin antitoxin and toxoid.

Dr. C. W. Larrabee recently addressed the Bradenton Optimist Club. He told of experiments being made to determine the source of the high iodine content of Florida sugar beets and brought out that it had been found that the burnt roots of the palmetto furnish this constituent.

* * *

Dr. C. J. Heinberg of Pensacola was recently elected president of the local Kiwanis Club.

* * *

Dr. W. J. Baker of Foley has proved that strawberries can be grown successfully in Taylor County. The first berries from his farm were picked before the middle of January.

* * *

Dr. C. B. Wilson of Sarasota was recently re-elected president of the First Trust Company of that city.

* * *

Dr. Gilbert S. Osincup of Orlando was the principal speaker at the January meeting of the local Parent-Teachers' Association. Dr. Osincup chose as his subject: "Immunization."

* * *

Dr. R. L. Hughes of Bartow has been appointed a lieutenant colonel on the Governor's staff.

* * *

Dr. C. C. Webb, Pensacola, acted as toastmaster at a "birthday party" of the local Kiwanis Club recently. Dr. Webb is a former president of the Club.

* * *

Dr. J. W. Hodges, who for some time has been located at Hampton, Va., has returned to Florida and is now house physician at the Gralynn Hotel, Miami.

* * *

Dr. and Mrs. Leigh F. Robinson of Ft. Lauderdale recently entertained the doctors of the Memorial Hospital staff and their wives, at a buffet supper at their home in Idlewyld.

* * *

Dr. E. W. Bitzer of Tampa and family recently spent some time in Ocala where they visited relatives.

* * *

Dr. W. J. Johnston was recently elected president of the Sarasota Kiwanis Club.

* * *

Dr. Gerry R. Holden, Jacksonville, was the guest speaker at the quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held at the Chattahoochee Hospital in January.

RALPH E. SMITH

Dr. Ralph E. Smith, a resident of Jacksonville for thirty-five years, died after a very brief illness on September 25th, at the age of 64 years.

Dr. Smith was born in Rome, Ga. He was a graduate of the Emory University Medical College and was lecturer and preceptor, at the Atlanta Medical College. He had been a member of the staffs of Gouverneur and Bellevue Hospitals in New York and also had practiced medicine in Atlanta, prior to moving to Sanford to take charge of the Fernald-Laughton Memorial Hospital.

Following his medical career in Sanford he moved to this city 35 years ago and for the last nine years he had been county physician. Dr. Smith was known and beloved by thousands of persons in Duval County and throughout the State for his charitable and benevolent work. Very little was said of his philanthropies and only his close friends knew the extent of his charity practice.

Dr. Smith, during his 35 years as a resident of this city, had been engaged in a general practice and much of his work had been with the railroad and steamship lines.

Surviving him are two sons, Carl H. Smith of this city and Ralph K. Smith, pilot of the Eastern Air Transport out of Richmond, Va.

WILLIAM BULLARD JORDAN

Dr. William B. Jordan of Ocala died at the Munroe Memorial Hospital, January 17th.

Dr. Jordan was born November 17, 1892, in Bartow, Washington county, Georgia, where in 1916 he was married to Miss Mary Lou Smith. He received his medical training at the Atlanta Medical college in Atlanta, Georgia, where he was graduated in 1914. For several years he practiced in that city.

In 1923, Dr. Jordan moved to Florida and began to practice at Homestead. In 1929 he went to New York where he entered the Postgraduate Hospital to begin specialist work in eye, ear, nose, and throat treatment.

A short time after the completion of his work he became house surgeon in the Bronx Eye and Ear Infirmary.

In March, 1931, Dr. and Mrs. Jordan came to Ocala where Dr. Jordan became associated with Dr. A. H. Freeman in the Holder building.

During their two years in that city, Dr. and Mrs. Jordan gained a wide and warm circle of friends and acquaintances. Both were socially prominent. Dr. Jordan was highly active in sports, and was particularly active in golf. He was a member of the Kiwanis club, secretary of the Marion County Medical Society, a member of the Florida Medical Association and the American Medical Association.

JOHN S. HELMS MEMORIAL ASSOCIATION

A meeting was called at the auditorium of the Tampa Chamber of Commerce Building Tuesday night, January 10th, for the purpose of organizing a John S. Helms Memorial Association. More than a hundred of Dr. Helms' friends, and citizens of Tampa were in attendance.

The meeting was called to order by Dr. H. Mason Smith, chairman of the committee from the Hillsboro County Medical Society on the John S. Helms Memorial and after a brief talk in which he stated the history of the movement and the purpose of the meeting he requested statements from others present.

A motion was made to form a memorial association, after which an organization and nomination committee was appointed which recommended the following named officers who were unanimously elected:

President—Peter O. Knight.
First Vice-President—Dr. H. Mason Smith.
Second Vice-President—Cody Fowler.
Third Vice-President—Mrs. Wm. M. Taliaferro.
Secretary—Dr. Bundy Allen.
Treasurer—R. J. Binnicker.
Members of Board of Directors: Geo. P. Raney, E. D. Lambright, T. N. Henderson, D. B. McKay, Judge L. L. Parks, Harry C. Culbreath, Isaac Maas.
Men's Advisory Board: Dr. W. M. Rowlett, J. A. Griffin, R. M. Prince, O. Falk, Dr. C. T. Young, Plant City; Collins Gillett, Rev. Francis S. White, J. W. Dupree.
Women's Advisory Committee: Mrs. A. C. Warren, Mrs. T. M. Shackleford, Sr., Mrs. Hugh C. Macfarlane, Mrs. Harry Roberts, Mrs. Hansard Foley, Mrs. J. A. Hansbrough, Mrs. Isaac Levy, Mrs. Joseph S. Mims, Mrs. L. R. Woods, Sr.

The type of memorial to be established for Dr. Helms was not determined at this meeting but there was some discussion on the subject and the consensus of opinion was that the best memorial would be a portrait of Dr. Helms in bronze on a large pedestal to be placed in some public park, probably Marjorie Park opposite the hospital. By action of the Association the directors were instructed to call another meeting of the Association in the near future at which time their recommendations for the type of memorial would be submitted to the organization.

A motion was made to have membership dues of one dollar annually, the money collected in this way to be used for the administration expenses of the Association, and all the people present registered as members at this meeting.

COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

The December meeting of the Broward County Medical Society was held at the home of Dr. Anna Darrow, who served as secretary-treasurer of the Society during 1932. Officers were elected for the year 1933, as follows:

President—H. J. Peavy, Ft. Lauderdale.

Vice-President—B. F. Butler, Hollywood.

Sec'y-Treasurer—O. C. Brown, Ft. Lauderdale.

Dr. E. M. Hendricks was elected delegate to the annual convention with Dr. Leigh F. Robinson, alternate. Dr. A. B. Connor of Hollywood was elected censor.

After the business meeting, refreshments were served by the hostess.

DADE COUNTY MEDICAL SOCIETY

At a meeting of the Dade County Medical Society held February 3rd, the following scientific program was presented:

"The Clinical Aspects of Nerve Blocking, with Special Reference to the Autonomic Nervous System," Gaston Labat, New York.

"A Suggestion Regarding the Treatment of Complete Suppression of Urine, as in Bichloride Poisoning," Carleton Deederer, Miami.

"A Few Remarks Concerning the Golden Rule in Medicine," P. L. Dodge, Miami.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

At the December meeting of the DeSoto-Har-

dee-Highlands County Medical Society, the following officers were elected to serve for 1933:

President—J. A. Simmons, Arcadia.

Vice-President—G. F. Highsmith, Arcadia.

Sec'y-Treasurer—L. W. Martin, Sebring.

Dr. H. V. Weems of Sebring was elected delegate to the state convention, with Dr. I. W. Chandler of Avon Park, alternate.

At the January meeting of the Society, Dr. Herman Watson of Lakeland was the principal speaker. He presented a paper on "Gall-Bladder Surgery."

DUVAL COUNTY MEDICAL SOCIETY

The first issue of a monthly bulletin by the Duval County Medical Society was mailed early in February. This little bulletin includes the names of officers and standing committees; the program for the next meeting; and two pages of text.

In addition to a splendid program at the meeting held February 7th, a number of important resolutions were offered and approved. These will appear in next month's Journal.

The following comments are reproduced from the February bulletin to which we have just referred:

"The committees are working splendidly. They are earnest and energetic, and we will soon begin to see the fruits of their labors. The entertainment and fellowship committee is framing up a year's program of social activities which should afford us ample opportunity to forget our troubles at least once a month; to brush elbows and get our best stories off our chests. We hear of golf matches, beach picnics, fishing trips, etc., but they have not arranged the entire program as yet."

"The medical economics committee is especially active and earnest in tackling the almost insoluble problems concerning us all with which they have to deal. They are meeting once a week, and plan to continue this during the entire year."

"The scientific program committee has worked out the programs for the entire year. We are sure you are going to like them and to profit by them. No long-winded and tedious papers are on the program at any meeting. Short, snappy discussions only."

LEE COUNTY MEDICAL SOCIETY

The annual election of officers of the Lee County Medical Society was held January 13th at the Lee Memorial Hospital, Ft. Myers. The following officers were chosen:

President—H. Quillian Jones, Ft. Myers.

Vice-President—Ernest Bostelman, Ft. Myers.

Sec'y-Treasurer—Robley D. Newton, Ft. Myers.

Dr. W. H. Grace was elected delegate to the next state convention.

MARION COUNTY MEDICAL SOCIETY

At a meeting of the Marion County Medical Society held January 25th, Dr. J. L. Chalker of Ocala was elected secretary and treasurer of the society, in place of Dr. W. B. Jordan, deceased.

ORANGE COUNTY MEDICAL SOCIETY

The annual banquet of the Orange County Medical Society was held at the Angebilt Hotel, Orlando, January 18th. Drs. G. H. Edwards, G. S. Osincup, W. H. Spiers and J. R. Chappell were in charge of the entertainment for the banquet which was a "stag" affair. The address of the evening was delivered by Dr. C. W. Stiles of Rollins College. Other guests of the society were Drs. J. W. Felty, Hartford, Conn.; E. C. McKee, Indianapolis; H. E. Osterling, Winter Park; H. Mason Smith, Tampa; Ralph N. Greene, Jacksonville.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. J. T. Bradshaw entertained the Pasco-Hernando-Citrus County Medical Society at Dade City on the evening of January 12th. A quail dinner was served at the Edwinola Hotel, which was followed by a scientific meeting at the home of Dr. T. F. Jackson. The following officers were elected for the ensuing year:

President—L. H. Dame, Inverness.

First Vice-President—S. C. Harvard, Brooksville.

Second Vice-President—J. T. Bradshaw, Lake Jovita.

Secretary-Treasurer—G. R. Creekmore, Brooksville.

Dr. T. F. Jackson was named delegate to the next convention of the Association with Dr. Geo. A. Dame as alternate.

SEMINOLE COUNTY MEDICAL SOCIETY

The following resolution was adopted by the Seminole County Medical Society at a recent meeting:

Be it resolved, by the Seminole County Medical Society that on account of the increasing burden of charity work and the feeling on our part that public health welfare is not the entire responsibility of the physician, although assumed by us in the past, we deem it necessary to withhold our services unless provision is made for remuneration, except the private charities of our own selection. We feel that under the present conditions, provisions are made to pay for every type of service rendered to indigents except medical service, and feel that it is unfair to expect us to carry this added burden as our just load. Our own private charities we expect to do in all graciousness as we have done in the past, but have resolved to withhold our services gratis from all agencies for doing charity where provisions are made for payment of every type of service except our own. We feel that the funds provided for these agencies are derived from taxes or gifts and we do our part by both.

Be it further resolved, that any member of Seminole County Medical Society employed as either city or county physician will adhere to duties prescribed by the city commission and by the laws of the State of Florida in such cases made and provided.

Adopted this the fourth day of January, 1933.

J. N. Tolar, *President;*
A. W. Knox, *Vice-President;*
J. T. Denton, *Sec'y and Treas.;*

Ralph E. Stevens,
C. J. Marshall,
C. M. Mitchell,
W. T. Langley,
S. Puleston,
H. D. Smith,
G. E. Selman,
C. L. Park,
J. W. Martin.

VOLUSIA COUNTY MEDICAL SOCIETY

The January meeting of the Volusia County Medical Society was held at the Halifax Hospital, Daytona Beach, January 10th at 7:30 p. m. Drs. J. Ralston Wells and J. H. Rutter presented papers. Guests of the society were: Dr. Gerry R. Holden, Jacksonville, president of the Florida Medical Association; Dr. Edward Jelks, Jacksonville, president of the Florida East Coast Medical Society, and Dr. S. E. Driskell, Jacksonville, a member of the Committee on Legislation and Public Policy of the State Association.



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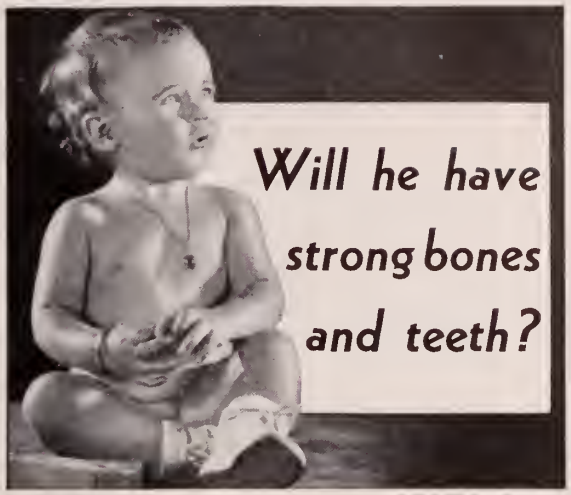
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The Florida Medical Auxiliary is pleased that through its invitation Dr. Arthur J. Cramp, Director of the Bureau of Investigation for the A. M. A., is to fill several speaking engagements in the state during the second week in March, one special address to be made to the State Convention of Federated Clubs at Avon Park.

* * *

Mrs. Shaler Richardson was the gracious hostess to the Duval Auxiliary which held its first meeting of the year in her beautiful new home on San Jose Boulevard on January 12.

The president, Mrs. George Beckman, introduced Dr. N. A. Upchurch, city health officer, who interestingly discussed various problems confronting the medical profession. He told of the need for a national home for doctors when they become too old to carry on their work and urged the enlistment of the Auxiliary in such a project.

After routine business a delightful tea hour was enjoyed.

Officers and committee chairmen to serve with Mrs. Beckman during the year are Mrs. N. A. Upchurch, vice-president; Mrs. G. H. Ira, Secretary; Mrs. F. L. Fort, treasurer; Mrs. Neil Alford, chairman of Hygeia; Mrs. Edward Jelks, chairman of public relations; Mrs. Thomas Palmer, chairman of publicity; Mrs. H. H. Harris, chairman of membership.

* * *

Those who are not familiar with the work often ask what there is for a medical auxiliary to do, and those already enlisted are seeking lines of greater usefulness.



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Our State Auxiliary adopted for its major project this year work along the line of Public Relations.

The following items taken from the monthly news letter just received from Mrs. Milton P. Overholser, national chairman of press and publicity, show something of what is being done in other states:

In Colorado, the Otero County Auxiliary is arranging for a health talk in each of their schools by some doctor or nurse.

The Denver Auxiliary is doing considerable sewing for the Red Cross. They have just made a gift to the loan fund of the Colorado School of Medicine.

Georgia Auxiliary has a Health Film Committee and under their direction health films have been exhibited throughout the state.

In Arkansas, Independence County Auxiliary offered a prize to a negro school for the best essay on Sanitation. Saline Auxiliary is sponsoring the printing in local papers a series of articles on Control of Communicable Disease. (Leaflets on such subjects are furnished free by the National Auxiliary through each state program chairman.)

Minnesota Auxiliary is now sponsoring an essay contest on the subject, "Why I Want to Live in a County that has a Public Health Nurse." This makes the children health conscious and opens up their minds to scientific medicine and medical research.

Pennsylvania reports an Auxiliary membership of 2,679. They are particularly stressing periodic health examinations. Something more than $2,000 was contributed to their Medical Benevolence Fund last year.

The Monongalia Auxiliary of West Virginia gave a prize last month to the Woodburn school for having the highest percentage of physical corrections, the prize being a two years' subscription to Hygeia.

An Auxiliary in Wisconsin is directing a Health Essay Contest among the state high school students based on readings of this year's Hygeia for February, March and April.

One rural county in Missouri reports: "This year, as last, the County Tuberculosis Society is co-operating with our Auxiliary in placing five months' subscriptions to Hygeia in 122 rural and town schools."

In this news letter sent out over the country, Mrs. Overholser told of Duval Auxiliary collecting the overflow of sample medicines and food preparations from the doctor's offices and carrying them to Brewster hospital to be used in their charity work.

Also of Pinellas County reading and discussing letters from state chairmen, and studying medical and health laws as related to state board of health activities.

An article from the out-going president of the Virginia Auxiliary—Mrs. J. A. Hodges, is well worth broadcasting. "No matter how efficient and faithful your officers or how excellent your program, the success of the Auxiliary depends upon the work and support of the individual members. Here are a few suggestions: First, attend the meetings regularly. If you cannot write a paper or make a speech be an appreciative listener. Your presence will encourage the president.

Second, if possible accept cheerfully the work assigned you and always be willing to do your part. Third, make constructive, not destructive, criticisms—the former are always welcome.

'A good thing to remember and a better thing to do—
Is to belong to the construction gang and not the wrecking crew.' "

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THE JOURNAL

—OF THE—

Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XIX
NO. 9

Jacksonville, Florida, March, 1933

Yearly Subscription, $3.00

NEW YORK ACADEMY OF MEDICINE
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American Medical Association, Milwaukee, June 12-16, 1933.

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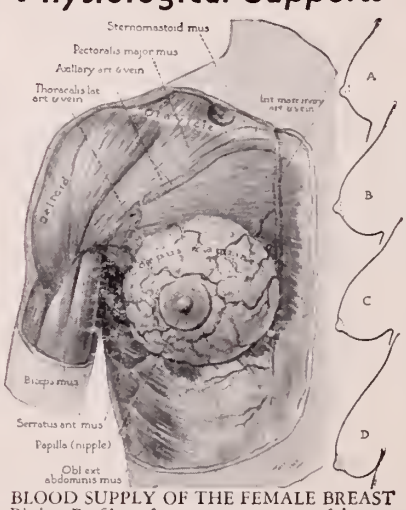
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XIX | Jacksonville, Florida, March, 1933 | Number 9

MEDICAL PIONEERING IN THE SOUTH

John Elliott Boyd, M.D.,
Jacksonville.

Some twenty-five years ago the negro living south of the Mason and Dixon line was a simple, carefree soul who gave little or no heed to the morrow. As a rule, he spent his earnings long before he got them, and because of this, whenever sickness overtook him he was obliged to keep on sharing his bed with other members of his family. The room which he had to be sick in was not only small, but very much crowded with all kinds of cheap furniture. The only ventilation it boasted was that provided by one tiny window and the usual gaping cracks. In time of sickness the shutter to that window would be kept tightly closed both night and day so as to prevent the possibility of a daught.

Colored people, as long ago as that, had a great fear that the slightest exposure to fresh air was apt to give the sick person a cold and from that bring about a pneumonia. This was why the only light the doctor had by which to see his way around in that room and make his examination of the patient came through the partly opened door. The sick man's family didn't call a physician in those days unless they thought their loved one was gravely ill, because they rarely ever had enough money with which to pay him for his visit. The negro physician was unknown at that time, and so the "colored folks" either had to seek help from the white doctors or do without. It is to the everlasting credit of the white physicians of the south that they always responded promptly and cheerfully whenever a negro called upon them for help; quite often, in fact, they spent hours in the nursing care of those "ignorant blacks" because there was no one to carry out their wishes intelligently. The sick man usually depended upon patent medicine to cure his ailment, which would be diagnosed by the corner druggist who sold the medicine after some member of the family had described the complaint. Those who were so unfortunate as not to be living with their families appealed to their friends to take care of them whenever they got sick. When their friends could not take them in, they were forced to accept the treatment offered by the county poor house. But, in doing so, both the patient and his friends would be desperately afraid that he would never come out alive.

Some ladies from a church society in the North, while making a trip through the South investigating the living conditions of the negro race, became so exercised over some of the things they saw as to induce them to urge their association to provide a place where sick negroes could at least receive better care than was possible in their own homes, and also where they would be treated more humanely than at the County Hospital. The town of Jacksonville, Florida, in which they proposed to provide such a place, is now one of the most flourishing cities of the South, but then had a population of only about 20,000, most of whom were negroes.

In putting their idea into practice, the society rented the upper floor of an unsightly weather-boarded building just around the corner from the city's restricted district. This building faced a street that was ankle-deep in sand, and the only sidewalk there was what was left of some pine boards which had been laid down a good many years before. The lower floor of this place was rented by a dirty Assyrian, who lived with his entire family in one small room at the back. In the front he peddled cheap groceries and half-ripe fruit to those who were too poor to buy anything better, or, oftentimes, to those who were too ignorant to care. In a small space just back of that and walled off from it by a cheap board partition, he passed out over a dirty bar to "poor white trash" and "no-count niggers" a "schooner" of stale beer and a gill of "rotgut" liquor, all for the price of ten cents. By pouring the liquor into the beer, these customers would usually manage to get a cheap drunk.

The church ladies seemed to feel that plain iron beds, equipped with cheap wire springs, shuck mattresses, homespun sheets, and cotton blankets, would be all it was necessary to provide in order to accomplish what their members wanted done. But they called the place "The Brewster Hospi-

tal," and this in spite of the fact that it lacked any of those things which are ordinarily demanded for the care and treatment of sick people. Besides the beds and food, there were a few ignorant colored girls to wait on the sick. Medicines, instruments, and surgical dressings; even the ice bags and the hot water bottles, or any of the things commonly found around the sick, had to be furnished by the patient's family or by his friends. Whenever a patient was going to need an opiate, for instance, the doctor would leave as many morphine tablets as he thought were necessary. He often relinquished his hypodermic syringe to make sure the man wouldn't have to suffer in case vomiting prevented him from retaining the drug by mouth.

A white woman of mature years and with only a meagre education came down from the North to take charge as its superintendent. Acceptance of such a position in the South twenty-five years ago isolated the woman from all social relations with those of her own race, and, at the same time, she found herself unacceptable to the people of the colored race. This woman, while she claimed to be a practical nurse, had no hospital training, neither did she have any previous experience in the handling of the negro race, and, moreover, she was addited to drugs. She experienced no difficulty in securing the services of young negro women who were lured by the attractiveness of becoming nurses. Those sturdy black girls thought nothing of doing all the scrubbing and the house cleaning, also, in case of need, the cooking. The hospital gave them uniforms, board, and laundry, and crowded them into one or two small rooms without causing them to feel that they were being badly treated. Nevertheless, nothing of a serious nature resulted from this insanitary arrangement, because those girls had been accustomed to such conditions all their lives. The matron was unable to give them any decent instruction in the practical art of nursing, but they were too ignorant to realize it. Really, very few of those nurses could either read or write, but in spite of that fact they all seemed to possess an innate sense of respect for the doctor, and a loyalty to the patients that might well be copied by the general run of nurses in our training schools of today. Nothing was too good for the doctor, and an opportunity to render him some personal service always was deemed a special privilege. Neither did those young negro women ever fail to show their patients the most thoughtful consideration; in truth, they seemed to give each one of them something out of their own souls. It is impossible to say too much in praise of young girls like those who served the sick with such a glorious loyalty, and always rendered, down to the very last dot, the respect due their superiors.

The only way to get to or from the upper floor of that building was by way of a walled-in stairway which had an entrance door of its own. At the head of the stairs you walked into a hall which ran down in front of all the rooms. You will easily see that the upstairs was a veritable firetrap, and especially so when made use of as a place in which to care for sick people. Ribald songs and drunken fights went on in the gin mill downstairs from the time it got dark each day until far into the hours of the following morning. This tended to keep all patients in the hospital from getting their sleep, and, for those that were desperately ill, it helped, no doubt, to hasten the end. No excuse could be offered for choosing such a place to care for sick people. The fact that the space was let for a very cheap rent only helped to aggravate the criticism showered down upon the society for such a selection, and this censure was aggravated because of the boast made by some of its members as to what they were going to do for the sick negroes of that community.

Every time you went into a room occupied by patients, you would knock up against a bed. Nevertheless, the room and everything in it would be found in the pink of condition. All the convalescent patients, as well as most of the others, would greet the doctor with a grin. Sometimes, though, there would be a patient who did not smile. He lay there on his back staring into vacancy with lusterless eyes; the relaxation of his jaw muscles caused his mouth to gape open; his tongue was brown, dry, and cracked, and the teeth were covered with a scum. Every so often he could be heard mumbling to himself, and was continually picking at the covers on the bed. One of those negro girls, who could neither read nor write would, as a rule, be found standing by the side of his bed. And as the tears rolled down her cheeks, she would wipe the clammy sweat from off the man's brow, wet his dry lips with a dampened cloth, soothe his restlessness with a stroke of her hand, and talk childish nonsense into his ear with the same crooning voice his mammy had used when she took him on her knee to rock him

to sleep. Once in a very great while, a smile would flit across the face of the dying negro, the pain-drawn lips would lose some of their tenseness, the weary eyelids would almost close, and the man actually seemed to drop off to sleep. This blessed rest, while it lasted for a short time only, seemed quite enough to repay the girl for the effort she had made to bring the dying man some surcease from his suffering. The doctor concluded his visit in that room promptly, and left it on the balls of his feet. What he had seen and heard would cause him to carry deep down in his soul the most profound respect for that ignorant black girl who was lavishing such tender kindness upon a dying man. Even now, after a lapse of twenty-five years, he quite often wonders what scientific progress has done to make any easier or smoother that lonely journey which everyone of us has to travel sooner or later.

If a sick person was broken out with an acute skin eruption, he was refused admission to the hospital for fear he might be suffering from a contagious disease. This, however, was the only precaution taken by the superintendent against the spread of infection. Segregation concerned itself with the matter of sex only. It was thought to be quite all right, during those days, to put a surgical case in a bed along by the side of one already occupied by a typhoid fever patient, and nothing whatever was thought about making common use of the dishes and bedclothes. It is only fair to state, though, that the dishes were immersed in boiling water after being thoroughly washed, and that the bedclothes were boiled before they were laundered. There were no screens in that building to keep out the flies and mosquitoes and neither did the patients enjoy the protection of a net. It was not known, then, that these pests could spread diseases. Quite often, therefore, a surgical case that was ready to be discharged from the hospital would develop a shaking chill, culminating in a high fever which later passed off with a drenching sweat. The doctor didn't have the slightest idea why his patient happened to get sick at that particular time, but, if he practiced his profession in the South, he promptly diagnosed the disease and treated it with much success. Sometimes a surgical case would be discharged from the hospital apparently quite well only to return a few days later with a fever which would prove to be typhoid. Everyone felt that those particular patients were having a streak of hard luck. The hospital authorities, as well as the doctor, would have been shocked had they been told that those illnesses could have and should have been prevented.

Twenty-five years ago, the performance of a major surgical operation in any city down South of less than twenty thousand inhabitants was a more or less rare occurrence. The surgeon who was competent to undertake it had to accept his cases from among those of very limited means or from the totally indigent. All white people that could afford it were advised by their physicians to seek the services of some one of the noted surgeons who practiced in the metropolitan centers. Owing to this fact, no hospital in those communities gave much thought to the equipment of their operating rooms. The one in this place, for instance, had as its entire equipment one oblong wooden table on which to put the patient, and a little square glass-top table on which the instruments and dressings were kept. Whenever the surgeon was going to operate, the nurses scoured this room until it was spotless, after which they rinsed it down with a strong solution of bichloride of mercury. The morning of the operation, every kettle in the house, as well as several big tin pans, would be filled with water and put on the kitchen stove to boil. Having seen to those details, the hospital felt that it had done everything it was in duty bound to do. The surgeon and his assistants would arrive from one to two hours before it was time to begin the operation, and they brought with them everything that was going to be needed.

The hospital not only looked to the surgeon to provide the things that were going to be needed for the operation, but it also expected him to attend to all the surgical details as well; he saw to the boiling of the instruments, the shaving and preparing of the operative field, and the making of all the solutions. His arrival at the hospital, along with the doctors who were going to assist him, was a great event. They drove up and tied their horses to the nearest hitching post or tree; then each of them gathered up as many satchels or packages as he could carry, and up the stairs they came, one following in the footsteps of the other. The doctors were just as much impressed with the importance of this entry as were the inmates of the hospital. Their faces would be set in grim lines, and they seemed to feel as if the weight of the world rested upon their shoulders. While they went along the hall towards the surgery, the nurses and all the patients well

enough to do so, could be seen peeping from around the available door corners. Things were so quiet in the hospital about this time that one might have heard a mouse run across the floor.

After seeing to all the lesser details, the surgeon scrubbed his own hands and arms, leaving the preparation of the operative field to the very last. Rubber gloves had not come into general use as yet so the doctor made every possible effort to sterilize his hands and arms. He scrubbed with a stiff brush until the skin was almost raw, then immersed his hands and arms in a boiling-hot solution of permanganate of potash; to remove the stain of this permanganate, he made use of a saturated solution of oxalic acid; and, as a final measure, put them into a particularly strong solution of bichloride of mercury. Even the toughest skins were irritated by this unusually harsh treatment, and it made the tender ones bleed. The skin of the patient's abdomen or other operative area underwent the same rough treatment, but the patient was relieved of any pains because of the anesthetic. Nevertheless, the bichloride solution was poured from a pitcher wetting the individual, his clothing, and all the coverings on the table, and he or she, as the case might be, would be left in those wet surroundings throughout the operation. The only reason why the resultant chilling of the body surface did not cause more cases of pneumonia probably may be explained by the extremely high temperature the surgeons insisted upon having in the operating room. The surgeon took it upon himself to supervise the administration of the ether, and invariably tried to do the assistant's work as well as his own. When the operation had been completed, it was the surgeon who dressed the wound, and, in almost every case, picked the patient up in his arms and carried him back to his bed. There, he saw to arranging the man comfortably, being most particular that all the hot water bottles were in their proper places. After having done that to his entire satisfaction, he found himself facing the problem of proving to the family that their loved one was neither dead nor dying. This he accomplished by slapping the man on his cheeks and dashing ice water into his face, all the while shaking him vigorously and shouting in his ear to make him open his eyes and say something. Strange as it may seem, it was the nearest relatives who approved most strongly of this barbarous procedure. The joy of seeing their man open his eyes and mumble a few words overshadowed the means employed in bringing it about. And, if the surgeon, by any chance, should happen to neglect that part of his responsibilities he could count on being subjected to the censure of both the family and friends, and it did not end there, because the hospital attaches, as well as his own colleagues, were always quite ready to add their quota of criticism.

Those who are in a position to appreciate the difficulties that confronted those Christian ladies so many years ago when they undertook to put into practice what was simply a humanitarian desire to better the surroundings of sick negroes, will not wonder why they failed to provide the most ordinary kind of things which are, today, deemed necessities even by the small hospitals seen in our rural towns. It must be recalled that this philanthropy was undertaken at a time when a real hospital was a distinct rarity except in our largest cities. Of course, this statement does not refer to the county hospitals or the alms houses. Therefore, in spite of the fact that they failed to provide what is now deemed essential to average good service, you cannot help but give them credit for what they tried to do—to better the surroundings of the sick negro—particularly that negro who would have been forced, in the absence of such a place, to go to the county institution. Moreover, those requiring a surgical operation were particularly fortunate in having such a place to go to, because, without it, they would, in all likelihood, have lost their lives. Of course, there were times when supervision by an untrained and uneducated superintendent tended to bring about a really serious situation.

For instance, the surgeon will never forget how he was stopped one Sunday morning not a great distance away from the hospital by a wild-eyed young doctor who rushed into the middle of the street and frantically waved him down. He begged him to go to the hospital to see a man who was dying, if not already dead. So, as soon as he reached the hospital, the surgeon rushed into the operating room to find a man lying on the table in what seemed to be a lifeless condition; his eyes were set in their sockets, and the only way the doctor was able to learn that he still breathed was by the closest kind of an examination. A doctor, with a face the color of chalk and the sweat running off it in a stream, was standing by the side of the table pressing down on a lot of blood-soaked gauze. Blood was over everything, a puddle having formed on the floor

where it had run off the table in a stream. Realizing that the man was almost dead, the surgeon jerked off his coat, dashed aside the bloody gauze, and as the blood welled up from the bottom of the wound thrust the ball of his thumb against the bleeding point. The hemorrhage stopped. The young doctors had accidently cut a big vein while trying to remove some diseased glands, and the gush of blood caused them to lose their heads. The patient happened to be a big powerful fellow who regained his strength in a very short time, suffered practically no discomfort from his loss of blood, and was fortunate enough not to develop an infection in the wound. So far as the surgeon knows, this man never did find out just how near he had come to dying. A situation like that wouldn't be apt to occur in these days, not even in the smallest of our hospitals.

After five or six years, the effects of the hospital were moved to a comfortable two-story house located in a very good neighborhood. Everybody was pleased to get away from the noise of drunken carousals, not to mention the odor of rotten fruit and cheap liquor. In spite of the fact that the matron set aside one of the rooms downstairs to be used as the surgery, a wide stairway with an easy ascent made the arrangement quite satisfactory. While the hospital was in this location, the largest abdominal tumor the surgeon had ever seen, or was able to find any record of after a careful research, was successfully operated upon. The patient was a negress around thirty-five or thirty-six years of age. However, she looked to be at least a hundred. The skin clung to her bones in a way that reminded you of a mummy, and whenever she stood upon her feet the growth would hang as low as her knees. She had reached the point where she couldn't get around except with someone on each side to help her. This patient was on the operating table under an anesthetic for nearly six hours. Even then, much of the sac of this enormous cyst could not be gotten away from its attachments at the back of her abdomen. However, such of it as was removed, together with the fluid contents that could be saved, weighed ninety-one pounds—over fifteen pounds more than the woman. Less than a year later, this same negro woman was making her living washing clothes. She had gained more than sixty pounds in weight, and looked the picture of good health.

The hospital did not remain in that locality for more than two years. Its equipment was moved then to a much cheaper house situated next to a dense negro settlement. About this same time the repeated complaints of both the white and colored physicians of that community forced the church society to purchase a second-hand operating table, install a pressure sterilizer, and demand that the young women applying for entrance to the training school have, at least, a common school education. A graduate white nurse was employed as superintendent of nurses, and three graduate colored nurses were engaged to act as supervisors on the floor. A new matron was in charge, because the other one had, according to her own favorite expression, "passed away."

There now arose a situation which never has been seen or heard of, either before or since, by the writer, in spite of his long experience with hospitals all over the world. This hospital for sick negroes which was being operated in the cheapest kind of a house, with less than thirty beds, and with the poorest kind of equipment, was carrying on its payroll a hospital superintendent, a superintendent of nurses, three floor supervisors (each one doing eight-hour duty), a housekeeper and an office secretary. When the times began to get lean, it was not at all an uncommon thing to find that the executives exceeded in number the sick people occupying the beds. The stairway in this house shot almost straight up, and it was uncomfortable for two people to try and occupy one of its steps at the same time. Getting the stretcher cases to the top floor, and moving those that had to be operated upon up and down those stairs was a heartbreaking ordeal. The stretcher was made out of a piece of heavy canvas swung between two wooden poles and having no crossbars to give it rigidity. This permitted the nurses to bring the poles together whenever it was needed, while the patient, of course, would disappear between the canvas folds. As a matter of fact, you were apt to worry about the sick person being smothered. If you chanced to be anywhere near when the girls started one of those trips you usually stopped to watch it. Here they would come along the hall, three husky negro girls hanging on to each pole. As soon as they reached the stairway, every one of them could be seen to tighten her grip. From then on, the trip was made a step at a time; each one seemed to feel that the responsibility rested on her, and so she was careful not to advance another stairstep until

she was certain that all the others were ready to do the same. They held their bodies like a steel poker; their eyes looked straight ahead; their teeth showed between the tightly drawn lips, and beads of sweat stood out all over their foreheads. As the end of the stairway was reached in safety, you heaved a sigh of relief and wondered how they had ever been able to do it. During the years they made those trips, maybe once or twice a week, or, again, as many times in a single day, no accident ever occurred.

Brewster Hospital made so little progress during the course of twenty-five years that it was beginning to bring down on its head the general condemnation of the public. In fact, the church organization whose members had felt called upon, years and years ago, to advertise widely their caustic disapproval of the County Hospital and the lack of provision made by the people of that community for the care of its indigent sick negroes, now found itself occupying the limelight of an equally bitter criticism. The County Hospital, about which they were so abusive, had, during the lapse of years, arisen from its stage of degradation into one of the finest institutions of its kind to be found in the United States. It was not only standardized by our leading medical organizations, but, by comparison, made this negro hospital seem an alms house in truth. This unfavorable contrast was emphasized further by the fact that the inmates of that place were being charged as much for their hospital care as were those who went to the best hospitals in that community. As an object lesson of what can occur in a place operated on such a standard, it is only necessary to relate how a surgeon in that city who was compelled to do an emergency tracheotomy for his patient at the completion of a goiter operation was forced to keep the woman on the operating table while a tracheotomy tube could be delivered from the outside and then be sterilized. Such a situation is no longer to be excused, even in a negro hospital.

Adverse public opinion and increasing complaint from the reputable doctors of that community finally compelled the church society to realize that what they had started twenty-five years ago as a place to improve the surroundings of sick negroes now had developed into a grave responsibility. Once the members of that organization had been made to realize that fact, they went to work to raise funds to correct it, and it was not a great many months before they secured enough money to erect two buildings, the substantial exteriors of which give ample evidence of the standard of equipment and service to be expected on the inside. And so, a charitable idea which budded forth in a plain weatherboarded building with the cheapest kind of furnishings and amidst the most repulsive surroundings, at last blossomed into an actuality of modern architecture, with up-to-date equipment, and located amidst the most ideal surroundings.

And so it was that one Sunday afternoon in the early spring of 1931, a large number of both white and colored people gathered on the slope of a newly made lawn under the shade of some big oak trees to listen to the exercises dedicating the fireproof buildings designed for the new Brewster Hospital and its student nurses. The hospital building, which occupies the top of a high knoll, overlooks a quiet little stream running along the side of one of the city's most beautiful parks which is just on the other side of the street. This city is not so very far away from the Atlantic and therefore enjoys its prevailing sea breezes. The patients in this hospital, owing to the reasons mentioned, share in the luxury of much sunshine, an unusually attractive view, and get the full benefit of the breezes because of the open sweep afforded by the park. Heavy traffic rarely ever passes through that part of the city and the nearest railroad tracks are more than a mile away. On account of these facts, the hospital is blessed with a peaceful atmosphere not usually found around the average institution of its kind. All of these advantages tend to make the location an ideal one for the purpose to which it is dedicated. The most outstanding fact, however, about this modern institution is that its service is limited to the use of the negro race.

The hospital building not only complies with the requirements of a fireproof structure, but the arrangements on the inside give ample evidence of the architect's experience in hospital construction. On the ground floor we find the executive offices; a general reception room; a room in which the doctor's record of his patient is indexed and filed away; a bacteriological and pathological laboratory; the main kitchen and general dining room; an emergency room; and the outpatient department. On the second floor are the X-ray department; the maternity beds, delivery room, and nursery; the operating department; and the wards and private rooms for the female patients. The third story to the front elevation has the wards

and private rooms for the men. Closed-in solariums are to be found at each end of this portion of the building on all three of the floors.

The corridors in this place have been made noiseless by the use of rubber tile. This floor covering not only does away with noise but it protects the feet of the nurses who hurry back and forth to wait on the patients. Every bed in the hospital, whether in a ward or in the most select private room, is of the latest design; the nurse can put a patient in any position required for his comfort or physical welfare by the mere turning of a crank at the foot of the bed. There is installed the most modern of ventilating systems so that all disagreeable odors from the kitchen, toilets, and waste sinks are practically eliminated. The wards in this hospital are small; they are planned to hold three or four beds instead of thirty or more as was usual in the past. This fact alone not only increases the comfort of those patients who are forced to accept its service but it adds largely to their protection. The provision made for light and ventilation is the same here as it is in the most expensive private rooms. The elevator service is of the doubly operated type and sufficient for all the needs of the building. When you come to inspect the arrangement of the kitchen and its equipment it seems that nothing was forgotten. Here are found all the things commonly seen in the kitchens of our very best hospitals and finest hotels. By the use of gas, steam, and electricity the smoke nuisance is practically eliminated. To those advantages there is a cement floor, a metal ceiling, and tiled sidewalls, in fact, everything that encourages cleanliness and the good preparation of food. The most modern food carts assure the patients of piping-hot meals at their bedside.

No longer do the surgeon and his assistants drive up in front of the hospital an hour or so before it is time to begin the operation and tie their horses to the nearest hitching post or to the most convenient tree, while they gather up an armful of packages which have to be carried to the operating room. Even in our small towns, say those which have only a few thousand inhabitants, it is the custom for the surgeon to make known his wants to his secretary sometime during the previous day or so, motor up a few minutes before the appointed time, change into an operating suit, scrub his hands in a simple sort of a way, and by the time a nurse helps him on with a sterile gown and a pair of sterile gloves he finds the patient all ready. He doesn't worry about the anesthetic, neither does he try to do other people's work, but confines himself to his own job and when that is completed goes about his business. Quite different from the way he acted twenty-five years ago! In spite of this marked efficiency and with all due deference to the scientific advancements made during those many years, there are still some things connected with the past which the older man does not forget very easily. Both the doctor and the patient of those days participated in a human side which somehow seems to be lacking since the appearance of all this modern cleverness.

There is no doubt that the emotional side was much more prominent then than it is now, and this was especially noticeable in a negro hospital because of the temperamental makeup of that race. From birth, negroes are surrounded by an atmosphere of superstition. They are in the habit, for instance, of giving vent to their deeper feelings by singing while they sway their bodies in a graceful rhythm to the time of the music; this is what you hear referred to as "shouting." Their folk lore, though, emanates from a native power to fill the air with a note which is weird, soft, and sweetly musical, but having the quality of reaching out to great distances; and this is known as "crooning." The "crooning" you hear on the stage and over the radio bears no resemblance to that which a "nigger mammy" sang to her baby, or the cotton pickers made use of to while away the hours in the cotton fields.

No one will gainsay the fact that the negro has had to wait a long, long time for just a few of the hospital advantages to which his white brother has been so long accustomed, but his day seems to be arriving. This up-to-date structure, which has been restricted to his use, may be taken as an example of what these people can look forward to in all other cities where they are still denied the privileges of hospitalization in the white man's institution. If a simple desire to better the surroundings of sick negroes, which was started a matter of twenty-five years ago with plain iron beds and ignorant help over the top of a saloon and in a disreputable district, can develop into a magnificent fireproof building with ultra-modern hospital equipment and be located in one of the most ideal spots in this particular city, then, surely, it is reasonable to look forward to similar developments in other places where the present hospital provision for the negro is now inadequate. County and city officials throughout the South have, for a number of years, shown the

same consideration, in their charity institutions, to the medical care of the indigent black man as was provided for his white brother. It is only lately, however, that the negro, who was able to pay for his hospital care, could secure a type of service justified by his financial independence. In this one city now, as well as in a few others in the South, the black man's money can secure him a private room with a bath; in fact, he may have all the seclusion and comforts which his white brother is accustomed to in our very best institutions; he can call to his aid the advantages of modern bacteriological and pathological laboratories, X-rays, first-class operating departments, obstetrical departments, and all the latest scientific apparatuses. Certainly, in this city, the negro man can buy for himself or any member of his family equally as good professional care and treatment as is enjoyed by the wealthiest classes of white people and this has been made real through the efforts of the white race.

SOME THOUGHTS ON THE ECONOMICS OF THE CHARITY PROBLEM*

Albert H. Freeman, M.D.,
Ocala.

Do you know that in charity cases treated at the hospital the only free work done is contributed by the medical profession? Of course you do; but, why should it be so?

You know, also, that each physician must pay $27.25 annually in license fees before he is permitted to practice medicine for money with which to provide for his own living, the needs of his family and dependents, or to treat charity cases free.

Do we pay less taxes on our home, our office, the tools of our profession, or anything we possess because of this contribution of our time, our skill, our equipment, to the care of the sick and needy? You know we receive no reduction in assessed property valuation, or a lower tax rate, because of our time and talent, our thought, our art, and skill, which we give above and beyond that of the average citizen to alleviate suffering, restore a seriously sick child to its anxious parents, or an invaluable mother to her precious children. True, we realize often a thrill of joy when we are able to contribute to the restoration to health of a charity patient, but our pay must be in the consciousness of a good deed well done—we get no other pay. No concessions or reductions in taxes are asked for by us, nor given to us.

When drives are put on for church, charity, or community purposes, or collections taken, the physician is not purposely omitted. We are expected to do as much as if we had not done $200,000 worth of service in the last decade for charity cases in our hospital alone, in Ocala, not counting the amount done for cases not hospitalized. If this was added to the above figure it would make a staggering sum, representing the aggregate for the medical and surgical staff *only* of the hospital, and not the whole number of physicians in the county. (The figure given is based on a fairly accurate compilation made at our hospital in 1928.)

The physician is, as a rule, a good citizen among us, progressive in the community, club, church, and school work, giving both time and money to their support. Besides supplying the needs of the community as physicians, we are an asset commercially, bringing people from the surrounding territory into the hospital or office for treatment, because friends and relatives accompany the sick ones. These must eat while here and they often utilize the visit to do some shopping at our stores, thus contributing to the volume of trade. We now draw our clientele from a fifty-mile radius and can increase that by intensive post-graduate study, making this a better medical center than it is at present. To do that we must improve our work by study and attendance at clinics, where the newer methods are explained and demonstrated. A week or two annually is not enough; it must be for a month yearly, or two months every other year. No man is as perfect as he might be; diagnostic methods can and must be improved. Study and observation are both required. The man who stops to rest will be left behind. Medicine has been revolutionized within my memory and will be again in the next generation, undoubtedly. The physician who does no post-graduate study gets into a rut, or groove, and becomes narrow himself to fit that rut or groove. He may be good, but is dwarfed by his failure to grow.

In my opinion, every professional man, to avoid ruts and hidebound conceits, must do post-graduate work at different clinics, hospitals, and in divers medical areas, where medicine and surgery are discussed and demonstrated by masters. The life of the physician is very strenuous, so much so that his span of life is less than that of the average business, trades, or professional man.

*Read before the Marion County Medical Society, Ocala, April 21, 1932.

The public might argue, "Let them die young; fresher men may fill their places," and the community move on much the same, but that is not economic. Some of our knowledge, skill and art is personally acquired and peculiar to each of us. To cut us off in our prime is to deprive the people of these accomplishments. They are poorer for this loss. Richness of experience makes the older physician possessor of a knowledge and mental equipment, gives him a training of judgment, a facility in touch and technique that is the acquisition of years of experience. The world is cheated by the untimely death of such a physician. To preserve these physicians and their skill and even improve upon it, is both desirable and possible, you will agree. How to do that will be presented later.

In the early days of medicine no charge was made to anybody, but an honorarium, presented by the grateful patient, served as pay. All were treated. The poor, having nothing, paid nothing, and they still continue to receive our services for nothing.

This system may have been the best when instituted, but has been abused to such an extent that it is now unfair, and burdensome, requiring physicians to do too much work for which they are not paid, so that they have not time, nor money, to take the rest they need to make them most efficient, nor to do the amount of study and post-graduate work that professional superiority requires and that would keep them abreast of modern thought and practice.

The public benefits directly by the improved quality of work the physician can do and therefore should encourage such rest, recreation and study that will keep him continually abreast of the times.

The largest clinic for medical and surgical treatment in the United States was built up by two doctors in a little hospital, in a cornfield, in the great northwestern part of the United States.

Thousands yearly now flock to this once small town for treatment, to secure the skill of the well trained medical group there; hotel and needed businesses have had to be built up to meet the needs of these many visitors, and the community prospers.

Would such a group be impossible in Ocala? Not at all.

What would happen in that event? Thousands would come here where now only hundreds come and, with their friends who must be fed, clothed and entertained while waiting for their sick ones to recover, the community would need to grow to take care of these visitors. Is this an idle dream? No, not if we wake up to our possibilities, our rights, our opportunities.

The Munroe Memorial Hospital could become a mecca for the sick and needy, the lame and the halt, with all that goes with throngs coming and going to a medical center. The commercial aspect is worth while aside from the good done.

Can it be done? Yes, certainly, because it is *right* and right being *eternal will prevail*—but, how?

About twenty men in Marion County pay this large sum in service, while 28,000 (the population of the county) reap the benefit, free.

As I said, we inherited this regime from the past, wasteful of the energies of the doctor, medieval, slavish and totally unfair; bad for both the physician and his clientele.

Fifty cents to one dollar collected annually from a population of 28,000 would be a small sum from each, but in the aggregate would raise a fund of $15,000 to $30,000 each year, which could be paid to the Marion County Medical Society for charity work we do, reckoned by a charge based on our minimum fee.

How can we put over such a program? First, sell ourselves on the idea that we want pay for charity cases, not personally, but for an improvement fund, that will give the county better educated doctors. This is still charity but will better conditions under which we work, improve us and give better service to all. Then when we are convinced this is desirable we will approach the County Commissioners to secure pay through the society for charity work. Failing to convince the present board we will attack the proposition through the candidates for next board and pledge to secure the election of men who favor us and *continue that line until we succeed. It can be done!*

What will we do with the money? This question need not really enter into the case. If it is right that we be put on a level with Mr. Average Citizen and be treated as he is treated we will receive pay for work we do for the people. But I prefer to tell what we want with it, instead of saying it should not concern anyone what we do with our money.

I would, if legally possible, incorporate the Marion County Medical Society and have it receive this charity fund in trust for the members of the society. What would *they* do with it?

Never having had any considerable sum of

money before we might be like the average poor relation who inherits part of a rich estate; it might burn our fingers and prove hard to hold.

We might do many things, but a few tentative worthwhile projects appeal to me.

I would:

1. Pay Medical Society dues, expenses, society endowment, etc.
2. Give every physician a one month post-graduate scholarship annually, or if he elects two months biennially.
3. Carry professional liability protection.
4. Build a Marion County Medical group second to none anywhere, details of which could be worked out later.
5. Establish a central laboratory, club, and reading room for reference, or study.
6. Have a public educational department.

As our ability increased, and it would, calls for service would also increase, internes might be needed and also additional help, employing more people. Income of physicians would be larger, because of people coming for our excellent group work and this would also mean more money for the hospital, for the merchants, as well as the doctors, a cooperative concern, the community, in which all profit.

Is this an Utopian dream? No, a feasible, sensible, workable, fair proposition.

Who profits most by this scheme? The people, town, and county. The archaic and unjust present scheme will be removed. This plan will not hurt the present group of physicians, but will tend to improve their condition, materially. The main idea is sound and will work out, the details requiring revision, or change, as occasion may demand.

This will be our first appeal for freedom from the old antique regime, that has served well its day, a day that belongs with the tallow dip for light, the ox-cart for transportation and the pony express for rapid mail delivery. It needs to give way to modern methods, modern fair-play and modern ideals. It is just, practical and progressive.

Physicians are the humble servants of the public and if our public can train us for greater usefulness and preserve us for more years of service it is good economy for them to do it.

Worthy indigent citizens needing medical or surgical attention will receive it just the same as at present with the added benefit of the improved skill we acquire; the county would be charged for the service at our minimum charge and the county commissioners would pay to the County Medical Society of Marion County at intervals the amount of the bill.

It is just, and right, to pay physicians for their work, even if paid to the individual physicians and let them add the amount to their already plethoric bank accounts and let them spend it for purely selfish purposes, or even unwisely. Some might improve their knowledge, others their golf strokes, both laudable undertakings.

I propose continuing to do this work for the sick and needy as through the ages, but inviting all citizens to share our joy in a community-wide enterprise, which at present is being paid for and enjoyed by only twenty men.

SUMMARY

Equality before the law should be accorded all classes of citizens without discriminating against any trade or profession.

The physician has long been a meek and uncomplaining burden-bearer for the communities in which he lives in doing charity work beyond and above any other class of citizens.

The days of electricity, the radio, the auto, the airplane, and countless modern improvements call for others in many lines, in ours perhaps, to keep pace with civilization's changes. We should investigate ours.

The economics of the present plan is bad for us, and if bad for us is bad eventually, for our clients, therefore should be changed.

TREATMENT OF PERFORATED ULCERS OF THE STOMACH AND DUODENUM

H. V. Weems, M.D.,
Sebring.

The earliest account of a perforating gastric ulcer was presented to the Royal Society by Christopher Rawlinson in 1729, and the earliest description of a perforated duodenal ulcer was written by Jacopo Penada of Padua in 1793.

The etiology of gastric and duodenal ulcers is still a matter of doubt, and until the cause has been definitely determined there will continue to be marked differences of opinion and lack of definite knowledge as to the treatment of choice. However, certain facts seem to have been determined: ulcers are found more frequently in men than in women, statistics varying from seventy-five to ninety per cent; ulcers are more prone to perforate in the male; duodenal ulcers are more frequently found than gastric ulcers; about two-thirds of all perforations occur between the ages

of thirty and fifty; duodenal ulcers are not prone to malignant degeneration.

But difference of opinion is marked in regard to whether gastric ulcers ever become cancerous. Stuart McGuire writes in the Virginia Medical Monthly, October, 1930, "A gastric ulcer should be regarded as a potential cancer and should be removed surgically as soon as discovered." Anthony Bassler in Medical Journal & Record, May 15, 1929, writes, "My experience has proved to me in the cases I have had and followed up, that gastric ulcer has almost no connection with carcinoma. Practically all ulcers that become malignant were cancer with ulceration at the start. And in those patients who have had an ulcer and in later years develop a cancer, who knows whether it came from the ulcer or started independently of it?"

Another mooted question relates to what proportion of perforating ulcer cases have previously had ulcer symptoms. Walter C. Mattingly in the July, 1931, New Orleans Medical & Surgical Journal, reports that in ninety-one cases, only sixty, or two-thirds, gave history of dyspepsia varying in duration from five days to fifteen years. On the other hand, William C. White, and Howard A. Patterson in August, 1931, Annals of Surgery, state, "It is doubtful if many acute perforations occur without any previous warning." John M. Blackford and Joe W. Baker in the American Journal of Surgery, April, 1931, write, "A striking point in the clinical histories is that only six of eighteen patients on whom histories were obtained were having stomach trouble immediately previous to operation."

The symptoms briefly are: sudden acute pain in the epigastrium radiating from or above the umbilicus to the circumference of the trunk. The patient presents an anxious expression, early a normal pulse and normal or subnormal temperature. Examination reveals a board-like rigidity of the abdomen, presence of pneumoperitoneum; Roentgen-ray may show subdiaphragmatic air. White cell count taken early varies from 8,500 to 16,000. It is surprising to note how infrequently vomiting is present when nothing is given orally. In about half the cases seen in the first twelve hours, vomiting has not occurred at all. In late case, rectal examination is valuable.

When the diagnosis has been made the treatment is always surgical, the sooner the better. In evaluating the mortality the time of operation is of paramount importance. One author reports that in seventy-two cases which were operated within twelve hours of perforation the mortality was 6.8 per cent; in those operated after the first twelve hours, 55.8 per cent.

The operative procedure to be employed is another question concerning which very able men differ radically. One school teaches that simple closure is best; another favors closure plus immediate gastro-enterostomy; still another, some form of pyloroplasty. It is argued that simple suture of the perforation is sufficient, is quickest, most safe, gives lower mortality rate, smoother post-operative course, that ulcers heal promptly and well, that if further operation is needed it can much better be done later, that gastro-jejunal ulcers often form after gastro-enterostomy and that a review of late results favors the simple closure. The main arguments for closure with gastro-enterostomy are: mortality not increased in early cases, post-operative course smoother, danger of pyloric obstruction obviated and second operation made unnecessary, that ulcers heal more rapidly and late results better.

The main points which favor pyloroplasty are: easily performed because of location of ulcers and that the ulcer-bearing field is entirely removed; a review of the late results reported by eight authors shows 269 cases treated by closure with only 66% satisfactory results, whereas forty-two cases treated by closure with primary gastro-enterostomy show 83% satisfactory results. Late results thus show 17% better with closure with plus primary gastro-enterostomy. However, these figures may be misleading, because the primary gastro-enterostomies were attempted in only the cases seen within the first twelve hours, while simple closure cases included those seen at various intervals after perforation.

The experience of this writer is limited and one would be presumptious to draw conclusions from such a small number of cases as it has been his privilege to treat. However, one does form certain opinions from one's own cases, which opinions are not changed by learning of the experiences of others. Therefore, the author may be pardoned for offering his present procedure, nothing original, for what it may be worth:

In the first place, the course to be pursued is not determined before opening the abdomen except in cases seen more than 12 hours after perforation. In these cases, simple closure with drainage is employed. In cases seen early, it is well to take into consideration the general condition and age of the patient, the size, location and appearance of the ulcer and whether other

ulcers are present; then it can usually be determined whether simple closure will be sufficient for cure of the ulcer and still not produce constrictions or deformity to any appreciable degree. If all things are favorable, simple closure without gastro-enterostomy is employed; traction is applied on the stomach so as to bring the ulcer into plain view, the ulcer margins may or may not be cauterized, interrupted sutures are then inserted traversing all coats of the gut, at least two sutures through the floor of the ulcer and the remaining sutures lying to the gastric and duodenal sides. The ends of each suture are left long and grasped in forceps. An archway of sutures is thus formed over the ulcer and extending beyond it in a longitudinal direction with the long axis of the gut. A long strand of omentum is pulled through the archway of sutures and its end sutured down. The sutures closing the ulcer are next tied off, not tightly enough to cut through the omental tissue. By this method there is caused very little stricture of the lumen of the gut. If the gastric or duodenal contents have been fairly freely spilled, a warm saline solution is poured into the wound and removed by suction. It has seemed that there is distinctly less pain after operation when this last procedure has been thoroughly carried out. It is probably unnecessary to drain when not too long an interval has elapsed since perforation.

Mr. D. H. A., age 64 years, was referred by a physician of Avon Park, Florida, on October 19th, 1931; diagnosis of ruptured ulcer of duodenum. He gave a definite ulcer history, duration over ten years. While feeding his chickens about five o'clock in the afternoon he was seized with sudden sharp pain. He was admitted to the hospital at 11:30 p. m. One hour later, operation was performed and procedure as outlined above carried out; duration of operation forty-five minutes. Proctoclypsis was immediately begun, water by mouth allowed on the following day. Sippy treatment begun on fourth day, patient remaining in hospital eleven days. Convalescence was smooth, temperature never above normal after first twenty-four hours and then never above 100.2 degrees. Only two hypodermics for relief of pain were required. In less than six weeks from date of his operation he returned to his work on a poultry farm. He continues the Sippy treatment and is at present free from symptoms.

Because of the fact that the author formerly employed closure of the ulcer with a purse-string suture plus immediate gastro-enterostomy, about half of the cases seen early have been treated this way. The last case was that of a city policeman, age 37 years, admitted to the hospital December 16, 1930. Perforation occurred at 8:00 p. m. and operation was performed at 2:00 A. M. the following morning. Simple closure with gastro-enterostomy was the procedure employed. His peritoneal cavity was not flushed with saline and not drained. The post-operative course was extremely rocky with some fever and a great deal of pain. He died on December 22, six days after the operation. What the outcome would have been with simple closure and thorough flushing of the peritoneal cavity is a matter of conjecture, but the author has come to favor the simpler procedure.

ABDOMINAL HEMORRHAGE*

Report of a Case

C. C. Webb, M.D., and
H. L. Bryans, M.D.,
Pensacola.

We desire to report a case not because of its particular rareness as to pathology, but because of its findings and as an evidence of the tolerant suffering of the female of our species.

The patient gave the following family history: father died, age 58, of cerebral hemorrhage; mother, aged 52, living and in fairly good health except for chronic cholecystitis at the present time, and thyroidectomy several years ago; one sister living and well.

She had a past history of: childhood diseases without complications; the removal of a nevus, pigmentary in type, in June, 1929, which was reported as a melanoma pathologically; a nervous breakdown following the birth of her first child in March, 1929, attendant to a very difficult labor of five days. A second child was born in September, 1931, normally. Her habits are regular; occasionally constipated; no alcohol or tobacco or other form of dissipation.

Her present illness began September 8th when she experienced a feeling of discomfort and pressure in her pelvis following the moving of a cedar chest during the hurricane. The feeling persisted until the 12th when she was seized with severe cramps in the lower abdomen which doubled her up, while attending a movie. She left the show feeling much pain and faintness which was re-

*Read before the December, 1932, meeting of the Escambia County Medical Society, Pensacola.

lieved at a local drug store until she got home in bed. This feeling returned, causing her severe pain and cramps all night, but because she was accused of complaining more or less all the time from imaginary ailments she refrained from consulting anyone about her discomfort. She found that by elevating her hips and lower extremities she obtained relief. At this time she started a profuse menstruation accompanied by severe pain which was eight days early and lasted fourteen days. About the 25th, her abdomen began to be distended. She thought it was gas distention and took a purgative without relief. By the 29th she was quite distended and walking with an awkward waddling gait with an extreme sense of fullness in lower abdomen, and laughingly said, "I am not pregnant, but I surely look like it."

On the 8th of October a laboratory examination revealed the following: trace of sugar indican and few pus cells in urine; red blood count, 3,100,000; total white, 11,000; polys., 68%, hemoglobin, not ascertained; X-ray of chest negative for tuberculosis but diaphragm dome shadow was elevated; heart shadow normal in contour.

On the 10th her physical examination revealed a white, fairly well nourished female, aged 29 years, walking with effort in awkward gait, and apparently anxious over her condition, complaining of light-headedness and slight faintness.

Her eyes reacted to light and accommodated to distance; nose clear of infection; septum not deviated and turbinates not enlarged; ear canals normal and drum lustre clear; teeth very good, no caries, gums were healthy; tongue not coated; tonsils had been removed with normal fossa; hair of splendid lustre, scalp clean; mucous surfaces were pale and anemic. The neck showed no enlarged cervical glands; the thyroid was not enlarged; thorax showed scar over left clavical about two inches long, healed and smooth; a nodule, size of a hazelnut, was freely movable subcutaneously in the left anterior chest wall over third rib area; mammary glands were normal in size, no nodules; nipples were normal in appearance; lungs had normal percussion note and vasicula breathing with decreased expansion. The heart was not enlarged, no arrythmia or murmur heard; the abdomen measured 36½ inches, increased about 4 inches in circumference in the past week; umbilicus obliterated by everted and ecchymotic; percussion showed typanitic note on ventral surface; dullness in both flanks, changing with the position changes of the patient. There was a definite succession wave; liver was at costal margin, no palpable tumors and no positive areas of tenderness; upper and lower extremities appeared normal; skin had a pallor and a moderate degree of lost tissue turgor; reflexes were all normal.

The abdomen was tapped with trocar and free blood passed; immediate operation was decided upon. A midrectus incision was made from the umbilicus to the symphysis pubis and several quarts of free fluid and blood was liberated. The left ovary cystic, about the size of a goose egg and degenerated, floated into view. The pedicle was clamped and it was removed; clots were cleaned out. The right ovary, about the size of a small grapefruit, was delivered from behind the uterus, but ruptured in the attempt. Contents were gelatinous in character. It was ligated and removed. Tubes and uterus were apparently normal but while drying the abdominal cavity an appendix about 3½ inches long, markedly injected and inflamed, was ligated and removed with inversion of the stump. A split rubber tube was inserted for drainage and the wound was closed. She was given an infusion of saline with hypodermoclysis throughout the first 24 hours. Her progress has been splendid since her operation and her condition is good. Diagnosis: cystic degeneration of both ovaries with hemorrhage from the right, and chronic appendicitis.

DISCUSSION

Dr. J. M. Hoffman, Pensacola:

I had the pleasure of seeing this case. At that time there was a characteristic appearance of abdomen containing fluid. The petechial hemorrhage about the umbilicus was suggestive of interabdominal hemorrhage. Trocar puncture established the diagnosis. The pathological condition found in operation was to my mind very interesting. Rupture of the ovarian cyst had undoubtedly occurred some time previous to laparotomy. Point of rupture was very small and, judging by the relatively small amount of blood in proportion to the amount of serum present in the abdomen, the hemorrhage must have resulted from an oozing about the margins of the rupture in the ovary. The appearance in a radiograph of this patient's chest of a rounded calcification in the upper left lung field suggested the possibility of a metastatic melanoma of the breast. Upon investigation, it was found that this density was caused by a small tumor freely movable in the thoracic wall.

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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CHANGE IN TIME OF THE ANNUAL MEETING

For the last year, there has been an evident desire on the part of members of our Association to have our state meeting so arranged that it would be in accordance with modern methods of travel.

The former arrangement of our meeting, beginning in the morning of one day and lasting until the late afternoon of the next day, has been very inconvenient for the majority of our members who drive in their cars to and from the meeting.

The Executive Committee this year is trying a new plan. Our meeting will begin at 1:30 on

Tuesday, May 2, and end at 1:00 on Thursday, May 4th. This will give many of our members, who drive to and from the state meeting, an opportunity to attend the full meeting and still only be away from home two nights.

The smoker will be held on Tuesday evening and the banquet Wednesday evening. Under the new Constitution and By-Laws, which will probably be adopted on Tuesday afternoon, the election of officers will take place at 12:00 o'clock noon on Thursday, the last event on our state program.

It is believed that this arrangement will be more acceptable to the majority of our members than that which obtained in the past.

IS IT FAIR COMPETITION?

Early in February the House of Representatives received the report of a special committee, appointed last summer, to study charges, that governmental competition was retarding private business enterprises in various parts of the country.

The report revealed that there were 232 examples of trade, industry, and personal and professional services affected by government competion and it made numerous recommendations, some of them sweeping in character. Two suggested changes in this report are of special interest to the medical profession:

First, the use of private hospitals and municipal institutions by the Veteran's Bureau instead of constructing new buildings to house the incapacitated; second, the employment of local surgeons, physicians and dentists for hospital care of veterans, so far as practicable. Both of these recommendations would seem to be founded on both economical and common sense grounds and are so inter-related that one could not well be carried out without the other. Why, with more than 200,000 vacant beds in civilian hospitals today and with many hospitals closing their doors because of insufficient revenue—thus aiding in a hardship to the community in which the closed hospital is located—should the Veterans' Bureau proceed with its hospital expansion program?

Private and municipal hospitals are local enterprises, usually sponsored by the better elements in a community and today are under an ever-number of paying patients, which are necessary mounting pressure to maintain an existence; for the call for free service is increasing, while the to offset the cost of the free care given, is falling off. Yet, our government, by building new hospitals for the care of its sick and disabled veterans is entering into a destructive competition with these semi-charity organizations instead of utilizing the vacant rooms and paying a fair price for the services rendered. If but one-half of the amount asked for Veterans' Bureau administration were used to pay for services in accredited hospitals, all the struggling hospitals would be relieved, better service could be given to the immediate territory, and many closed hospitals could be reopened.

There can be no question but that the quality of service rendered by a physician or group of physicians, whose livelihood depends upon professional ability, and the success resulting therefrom, could and would give as good and, in most instances, much better service than that offered by the individual whose income depends upon the number of hours on duty, instead of results obtained.

A third recommendation might well have been made by this committee, that is limiting the work of Army and Navy and Veterans' Bureau surgeons to the personnel and inmates of the posts or hospitals where they are stationed. These surgeons, on a salary, with quarters and office equipment furnished by the government, should not be permitted to offer services to the residents of any locality in competition with the local physician, who has to fend for himself. If there is not enough work for the government surgeon at the place where he is stationed, it would be a measure of economy to reduce the roster to the number needed.

We do not look with envy, but rather with compassion, on our confreres in St. Petersburg, if this picture of competition presented in many cities and at other posts is to be reproduced there. While Congress with one hand—probably the left—talks of banning competition with private interests, it is planning with the other—the right—to extend the blanket of free medical care so that it will cover all representatives of the A. R. C., Y. M. C. A., K. of C., Salvation Army, etc., who served in welfare work overseas. Are you convinced that this governmental and Veterans' Bureau competition is a fair one?

POST-GRADUATE MEDICAL COURSE

Plans are nearing completion for a post-graduate medical course to be offered to the doctors of the State by the University of Florida Extension Division and sponsored by the Florida Med-

ical Association, according to an announcement made by Dr. Gerry R. Holden, president.

A committee, appointed by Dr. Holden, composed of Dr. T. Z. Cason, Jacksonville, chairman; Dr. G. C. Tillman, Gainesville, and Dr. T. H. Bates, Lake City, has been at work on the arrangements for the project during the past several weeks, in collaboration with Dean B. C. Riley of the General Extension Division and Mr. W. K. Mitchell, Secretary of Institutes and Short Course Bureau, at the University.

As outlined by the committee, the course will consume six days, June 19th to 24th. It will include six lectures each on surgery, obstetrics, pediatrics, and medicine, and two each on eye, ear, nose and throat, dermatology, laboratory work, and X-ray. All subjects will be considered from the standpoint of the general practitioner and not from that of the specialist in these various subjects.

The lectures in the major courses will be given by full professors from various medical schools. Dr. Wayne Babcock, Professor of Surgery in Temple University of Philadelphia, has kindly consented to give the course in surgery.

Further information concerning this course will be sent out soon by the Extension Division of the University of Florida.

THE TUBERCULOSIS FIGHT

People are "conscious" of tuberculosis. Years of persistent education have made them so. Most adults know, in a general way, the influence that favor development of the disease and have a groping knowledge of precautions to escape it. The fatalism of a previous generation has given way to a hopeful attitude, for most people now know that tuberculosis is preventable and curable if diagnosed and treated early in the development of the disease. Many are familiar with the danger signs of advanced disease, such as loss of weight, blood spitting and fatigue, and when these appear, respond to the advice preached over and over again, "Let Your Doctor Decide."

For the past five years, those interested in the prevention of tuberculosis, under the leadership of the National Tuberculosis Association, have attempted each year to focus attention on a single aspect of tuberculosis. Vague knowledge must be refined and particularized. This year the topic chosen is well expressed in the slogan, "T. B.—From Whom Did He Get It?—To Whom Has He Given It?—Examine and Protect Every Contact." In some of the posters and leaflets this slogan is coupled with a picture of a physician studying an X-ray plate, to suggest not only that the diagnosis is not complete until the questions have been answered by an examination of all contacts, but also that the X-ray is today a necessary diagnostic aid.

Tuberculosis is steadily declining. Even three years of depression have not yet slowed the downward trend. Although the reported death rate in Florida for the year 1931 shows an increase of 2.2, this is not believed to be significant as slight fluctuations from year to year have occurred in the past, with the trend steadily downward.

But there is danger in apathy bred of a sense of security. Public interest in the problem is probably waning because the harrowing reminders of the disease are fewer than they ever were. The deep emotion that fired the anti-tuberculosis crusade of bygone days can no longer be counted on to carry on. It is necessary, however, to finish the fight and the old fire must, therefore, be replaced in this day by intelligent understanding. For this, leadership of the medical profession is essential.

GOVERNMENT COMPETITION

The following letter has been forwarded to the representatives in both Houses of Congress. The sentiment expressed in this communication cannot but appeal to both medical men and laymen as just. In every community members of our organization should contact their congressmen, urging them to understand that competition of the government with the medical profession is as unfair as it is in any other business:

"On behalf of doctors, dentists, nurses and civil hospitals of Florida, we wish to present the following facts for your consideration:

"Because of the present economic status the incomes of the foregoing professions have been much reduced, in many instances very greatly reduced. Hospitals are receiving less from their pay patients and are doing an increased amount of charity work. We believe that every hospital which does philanthropic work in our State is running behind in its expenses.

"If the Veterans' Bureau would hospitalize its patients in local civil hospitals and employ local doctors, nurses, and dentists to care for these patients, assigning this work as far as possible according to desires of patients, we believe that the results would be mutually beneficial. Proper

attention could be given to the majority of patients by this system as we have many vacant beds in Florida hospitals and our professional personnel is by no means working full time. By such action we believe that the following advantages would be gained:

"(1) Avoid the construction and maintenance of additional government hospitals.

(2) Expense of treating patients in many instances would be less than under the present system.

(3) Patients would be cared for in their home environment.

(4) Local philanthropic hospitals would be financially benefited.

(5) The doctors, dentists and nurses of Florida would have returned to them a portion of the practice which the present system is now taking away from them. Their financial condition would be benefited at no loss to the Government and without detriment to the patients.

"These three professions, with their dependents, represent several thousand of your fellow citizens, who have for a number of years suffered from this government competition. Our only source of help is to appeal personally to those who represent us at Washington and to urge that you give all possible assistance toward remedying these conditions.

(Signed) Gerry R. Holden, M.D.,
Pres., Florida Medical Association.
(Signed) W. Lawson Shackelford, M.D.,
Pres., Florida Hospital Association.
(Signed) Andy W. Sears, D.M.D.,
Pres., Florida Dental Association.
(Signed) Kathryn R. Gutwald, R.N.,
Pres., Florida Nurses' Association."

RADIO BROADCASTS, 1931-1932

The following broadcasts were arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

THE ECONOMIC VALUE OF SCIENTIFIC MEDICINE*

H. C. Dozier, M.D.,
Ocala.

In discussing the economic value of scientific medicine to society, it is necessary that we know something of the value of a man's or woman's life. This value of life has many angles, depending on the particular individual, and on whether we speak of his value to his wife, children, relatives, his business associates, or to the state or the world at large. His life is priceless to the wife or child, and who would gauge the value of a mother? There is a definite economic value to every life, however, not only to the relatives, but to the state. All are producers of goods; all are creators of wealth, be it great or small. These values have been worked out in dollars and cents, by such statisticians as William Farr, Irving Fisher, Louis I. Dublin, and Alfred J. Lotka.

Among the factors that tend to depress the earning capacity and hence the economic value below the average, the most important, because the most common, is *disease*. Disease adversely influences the economic value of every individual. It produces partial or complete incapacitation; it causes, in the majority of cases, certain items of special expense for medical, hospital and other services; it may actually terminate life, or shorten it many years.

Disease may leave behind it such impairments as blindness, deafness, lameness, which usually curtail to a greater or lesser extent the earning of the afflicted individual.

It is therefore in the control of disease, in the lessening of man's incapacity and the prolongation of his years of usefulness to his loved ones and the state, that scientific medicine has demonstrated its economic value to society, and its value to the happiness and contentment of each and every member of society.

It may not be known to most of my listeners what medical science has really contributed in this regard, and hence the Florida Medical Association wishes to present some of these facts for your consideration and for your information.

Between 1881 and 1889, during DeLesseps' attempt to build the Panama Canal, 16,000 white employees died of tropical diseases, and 9,000 of them succumbed to yellow fever. In 1929 statistics showed that only two Federal employees, one white, and one negro man, had died in the Canal Zone from any tropical disease in the previous 8 years. Was not that an accomplishment of scientific medicine, through the efforts of Dr. Gorgas? Few realize that the French failed in their efforts to build the Panama Canal, not through any lack of engineering skill, but because they failed to realize that the brains and bodies of man cannot function in the presence of crippling and incapaci-

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, February 10, 1932.

tating disease, and did not engage the forces of scientific medicine as a necessary preliminary to their engineering efforts. It is said that at one time when the American engineer, Gen. Goethal, was building the Canal, he told Dr. Gorgas that the killing of his mosquitoes was not worth the cost. Dr. Gorgas replied that if his efforts would result in the saving of one life it was worth it, "particularly if that one life was yours, General." Needless to say he heard nothing else about the cost.

In the last 30 years the science of medicine has won mastery over yellow fever, plague, malaria, black water fever, relapsing fever, African sleeping sickness, the dysenteries, typhus fever, syphilis, yaws, pellagra, hookworm, and leprosy. It saves millions of men every year; more, it has become a most important factor of practically limitless power in the world's economy.

Scientific medicine opens up vast territories hitherto closed to the white man and his enterprises, and makes for better living conditions among the inhabitants; it makes possible the development of vast resources, thereby contributing both to the wealth of the world, and the happiness of its people. In the July 27, 1931, issue of *Time* appeared the announcement that "Dr. John D. Long and Dr. Clifford Eskey of the United States Health Service have just wiped Bubonic plague from Peru and Ecuador by killing 4,400,000 rats in two years." The rat is the transmitter of plague, which fact was a discovery of scientific medicine, and the application of this fact by our health departments wipes out the disease. Many of you can remember the scare which would grip our population, when yellow fever appeared in Cuba, Key West, Jacksonville or New Orleans. The discovery by scientific medicine of the mosquito which transmits yellow fever has put an end to that, and the state is able to develop without this handicap.

We are so accustomed to our relatively salubrious conditions that we fail to appreciate our present benefits. It is instructive to read the descriptions of the quarters of the poor in New York about 1860 as written by Stephen Smith, the Commissioner of Health, and also the Board of Health reports of New York from 1868 to 1875. New York City at that time had over a million inhabitants. We read: "There are more than 400 families in the 4th ward, whose homes can only be reached by wading through a disgusting deposit of filthy refuse," "18,000 people live in cellars." The inspector of the 25th ward reports "in a dark and damp cellar, about 18 feet square and 7 feet high, lived a family of 7 persons; within the past few weeks two have died of typhus fever, two of smallpox, and one has been sent to the hospital with erysipelas." The constant death rates in some districts ran to 50-60 or even 70%.

Such facts as these, taken with a general view of the present day conditions, may well be commended to the consideration of any persons, who may be inclined to make light of the economic benefits derived from the efforts of scientific medicine in sanitary improvements, social and public health administration.

I wonder if the average person appreciates the value of the wonderful discoveries of Pasteur, which had an infinitely more beneficial influence on humanity than all the victories of the world's military forces. To it is due the marvelous accomplishments of present-day surgery. Almost everyone knows the ease and safety of abdominal and other operations; and since the World War the deadly gas gangrene and lockjaw or tetanus have been robbed of most of their terrors.

Time will not permit any further mention of the many accomplishments of scientific medicine, such as the victory over diphtheria and the many other diseases through the use of vaccines and serums, but I must mention just one more. Scientific medicine and the scientific physicians have added some years to the span of man's life. In 1901 the average length of life at birth for a male was 47 years, and 50 years for females. In 1927 for the same registration area, the length of life for males was 57.9 years, and for females was 61 years—a gain of 10 and 10.3 years respectively.

It is the desire of the group of physicians and surgeons comprising the Florida Medical Association, which is the representative of scientific medicine in this State, that the general public know something of its accomplishments for them, and to appreciate scientific medicine's contribution to the health and happiness of our citizens, the good that its discoveries are to the economic development of our cities, our resorts, and the entire State. Also, it is hoped that this knowledge will arouse your interest in assisting scientific medicine to make available for your state all the advantages of her many marvelous discoveries, and to arouse in you an appreciation of health, the country's greatest asset, economically and socially.

THE MEDICAL PROFESSION; ITS VALUE TO SOCIETY*

M. A. Lischkoff, M.D.,
Pensacola.

The practice of medicine is as old as the dawn of human intelligence; it has been said over and over again that the first doctor was some caveman in whom suffering first kindled in his heart emotions of pity and sympathy. It was from this germ that the practice of medicine was born.

We are wont to consider the doctor as one whose life is necessarily narrow, because his sphere is so often circumscribed, but his submergence of self and devotion to others, makes altruism his daily life. The interests of the community and his patients are his first consideration.

There are many phases of his activities that are magnificent; the free service given to our hospitals and institutions, the care and instructions to expectant mothers, the care of the feeble and insane, the associations for the prevention of blindness, tuberculosis and heart disease, the efforts to stamp out venereal disease, and many others. The list of accomplishments in prolonging life and preventing disease is never ending.

We often hear of the great engineering undertaking of building the Panama Canal. It was planned by engineers who could never have brought it to a successful conclusion without the doctor's aid. The tropics were unlivable for white men; yellow fever, malaria and tropical fever were prevalent and killed white men, no matter how brave and strong, but with the aid of the doctor this great engineering feat was successful.

For many years the medical profession was charged with the responsibility of combatting disease when found, and of devising ways to prevent disease from attacking us. The responsibility was too great and unfair. The fight against disease is every man's fight and every man should help; the laity should bear their just share of the responsibility for protecting themselves from preventable illness or other misfortune. It is an obligation of the medical profession to keep the public informed regarding disease and to advise with the various groups regarding their part in the fight. Society holds the profession responsible to furnish medical service. We cannot escape the fact that upon the shoulders of the profession rests the responsibility of the health of society in general, just as the church is responsible for its moral and spiritual welfare.

Organized medicine should assume leadership in all activities bearing upon the problem of health and disease, and that it can best do by cooperating with other agencies and organizations. Modern science and its rapid development has placed a new conception on health. Health today is a state of mental and physical fitness in individuals resulting from the interaction of a vast number of conditions which include heredity, diet, sleep, dress, vocation, habit, mental attitudes, immunization, housing, income, social stresses and strains and many others.

The great single antagonistic element to medicine today is the high cost of medical service. It has been said that only the well-to-do and the poor can get proper medical attention.

Does medical service cost too much? In comparison with other recognized necessities, I doubt if the proportionate cost is excessive. If the public could be educated to an understanding of the economic necessity of maintaining health, they might then assign a fraction of the annual income to medical care. And if, when it was not used, it would be deposited in a savings bank and kept for a rainy day, the amount when required, would not seem excessive, and the doctor's bill might be paid. The difficulty is that it is generally assumed that health will be maintained somehow, and when disease occurs, it is looked upon as an accidental disaster, outside the normal course of life. Yet it has become apparent that good health underlies efficient workmanship.

Public health is purchasable. Is it too much then to ask that the public lay aside ten per cent of its income for medical service? If it is conceded that the foundation of economic safety is built on health, I do not believe that proportion is excessive.

The first concerted movement in public health was in relation to our sanitary environment in providing safe water supplies and adequate sewage disposal systems. This movement has almost completely eliminated typhoid fever and dysentery, and has bettered the health of every age group in our population. Statistics show that man's life has been lengthened nine years in the last quarter century. The average age at which a citizen of the U. S. died in 1901, was approximately 49 years; in 1926, it was about 58 years. It is not improbable that it will soon be extended

*Broadcast delivered under auspices of Florida Medical Association, over Station WRUF, Gainesville, March 16, 1932.

to seventy years, yea, three score and ten. Each mammal except man, lives approximately five times as long as it takes him to get his growth. Why should man not live equally as long or about 120 years?

Just before the introduction of antitoxin in the treatment of diphtheria, the death rate per hundred thousand was 116; last year it was less than seven; fifty years ago tuberculosis caused 320 deaths per 100,000 annually, last year it had been reduced to 74.4. Typhoid caused 100 per 100,000 at the beginning of the century, now less than 15. Soon diphtheria and typhoid will be eliminated.

The public is being educated to the importance of medical science and to an appreciation of what may be accomplished by the general application of medical knowledge, not only in curing disease and alleviating pain, but in preventing disease.

If you ask the question, "Is the practice of medicine worth while?" I would answer "If the living of life is worth while, certainly the saving of life is worth while."

The profession is to be lauded for not exploiting any of its discoveries, but it is only within the last few years that the laity has had a small chance to know something of the men who have done the wonderful work. A knowledge of the attainments of modern medicine should become a part of the common heritage of every citizen.

Pasteur dispelled the ignorance of centuries by his demonstration that certain diseases are produced by specific organisms; Koch by the development of culture media and analine dyes, made possible the identification of the germs that cause such diseases as tuberculosis, lockjaw, and many others. Crawford W. Long, a Southern doctor, gave us modern anesthesia that made modern surgery possible; Roentgen gave us the X-ray. You may know that Oliver Wendell Holmes wrote "Old Ironsides" but probably don't know that he was a practicing physician whose observations were of untold service to humanity.

The border line between superstition, quackery and credulity is so narrow that it is often hard to differentiate the terms when applied to cases in general, as the human being has so much of all three in his make-up, whether he be the lowly peasant in the fields, or the giant intellect in science, art and letters. The refrain from Kipling that the "East is East, and West is West, and never the twain shall meet," is incorrect in that the East and West have a common meeting ground in their belief in magic, the unnatural and the inexplainable things of life.

There are hundreds of harmless superstitions that are sincerely believed by the public, not necessarily by the ignorant public. Not long ago, the children of the best families wore asafetida bags around their necks to ward off contagious diseases.

As one stone added to another gradually lays the foundation for a house, so the piling up of the truths of science gradually unfolds the mysteries of organic and inorganic matter.

Owing to the various forms of drugless healing, confusion has arisen in the administration of medical practice laws, through misconception of what is meant by this simple term, practice of medicine.

It is evident that anyone who is to treat human disorders, regardless of the method used, should have a knowledge of the fundamental sciences by which he can make an accurate diagnosis. It follows also, that the educational qualifications required of one, the physician, should be required equally of all who profess to treat the sick.

The public demands that a regular doctor of medicine should have at least four years in a high class medical school and pass a rigid examination before a state board. It should require equally as much education of those who prey on the public under many guises, but who to all intents and purposes, are quacks, preying on the superstitious, on the helpless and ignorant.

The progress of science in the last few years has been the most rapid and wonderful of any period in the history of the world. Just as people are no longer content with old-fashioned methods of farming and business, they are not content with the old-fashioned doctor as he used to be. Modern science has brought about changes that altered the relationship between the public and physician which makes us submit more and more to that division of labor which has been a condition of advance in all other walks of life. Medicine is making rapid transition from the curative to the preventive emphasis to avoid broken health. Health education is the apex of the preventive program.

Every man and woman should understand the work of public health departments in nation, state and community. They should know about the chief agencies, public and private, devoted to health work; they need this knowledge as a social

problem. Without this, health progress is impossible, especially in a democracy like ours. Here lies the chief reason for the niggardly support of health in all our public budgets. People build beautiful public office buildings, ornate bridges, scenic highways, great white ways and decorative parks, without murmur; but they permit health departments to be housed in old buildings with meagre equipment and low-salaried staff. Tuberculous cattle can get an appropriation more readily than tuberculous children. Adult health education alone can remedy these faulty evaluations.

Insurance companies are rapidly working out policies of medical examination, health advice, and educational literature for their patrons. It is but a short step from these policies to that of a comprehensive system of cooperating physicians, distributed over the entire country. People will become accustomed to the life-prolonging practice of "periodical health examinations" and much serious disease will be discovered in its early and curable stage.

Present-day efficiency requires such infinite knowledge of details of the professions, in industry and in commerce, that it is impossible for any one person to be sufficiently versed in all the phases of any one line of endeavor, hence the evolution of the specialist. This obtains in all professions and in business of every description there is no exception to this condition of affairs. Why, then, should the medical profession be called upon to take a backward step in the conduct of its affairs?

In medicine, knowledge has increased by leaps and bounds. The science has grown so rapidly and extensively that no one man can handle thoroughly more than a small part. That means specialists in various lines.

Cushing, in his "Life of Sir Wm. Osler," quotes from an address made by Osler to students, "More than any other, practitioners of medicine may illustrate the great lesson, that we are here not to get all we can out of life for ourselves, but to try to make the lives of others happier. The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head." A president of the A. M. A. said, "We, as physicians, need not complain that the results of such a life, when they are what they should be, are unappreciated by the public, even though they be not the subject of daily comment on the front page of the newspaper. It behooves us rather to look to it that we deserve and preserve the enviable reputation that is ours."

The unsolved problems should cause no dismay, but in the light of past conquest, stimulate the profession to increased effort. Truly the medical profession can point to the accomplishments and proudly say "By Their Deeds Ye Shall Know Them."

COMMUNITY HOSPITALS*

John A. Bowman,
Supt. Munroe Memorial Hospital,
Ocala.

The growth of the American hospital has amazed the world. In 1900, we had less than one thousand hospitals; today we have reached approximately eight thousand hospitals and a million beds. The approximate valuation of hospital facilities is nearly five billion dollars.

Hospitals are governed by all sorts of state laws and municipal regulations. They are concerned primarily with the care of the sick and they constitute the working places of physicians. The strange view has sometimes been shown that the public provides the physicians with the hospital as a working place. Nothing could be further from the truth. A hospital without physicians is merely four walls with a lot of beds and apparatus. The physicians make the hospitals, and the standing of any hospital in any community depends on the type of medical men who constitute its staff and who practice within its walls.

Serving first to function for the care of the sick, the hospital is also concerned with the education of the intern, with the education of the nurses, with the conduct of research in the field of medicine, and with the education of the public which it serves. There is no institution in any community of greater importance to that community than the hospital which serves as its health center.

The hospital has become increasingly a place for the practice of medicine as well as of surgery. In most large institutions today the beds devoted to internal diseases, care of the mother and new born babe, diseases of children and the medical specialties far outnumber the beds available for surgery.

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, April 20, 1932.

As the character of medical practice has changed, physicians have become more and more dependent on the laboratory. In many instances, brains have been largely replaced by glassware and machinery in the laboratory, but the brains of the educated physician will always be necessary to interpret and apply the laboratory tests. Laboratory observation is scientific observation, measurable, accurate and standardized. To determine proper gland function and the electric heart measuring apparatus and other equipment are far too costly for the individual physician to maintain for his own practice alone; their use must be distributed among groups of physicians in various ways. The hospital staff is such a group. Laboratories have been developed in response to this demand. Such facilities must be administered according to the highest standards. A life may depend on the question of a plus or a minus in a laboratory test. A wrong answer concerning the content of sugar or the question of albumin in some of the body fluids may mean ten years less in the life of the patient concerned.

The nurses' training schools have risen tremendously in number, constituting a significant part of any large or small hospital. Whereas only 318 nurses were graduated from nurses' training schools in 1890, more than 18,000 nurses were graduated this year and it is predicted that 65,000 nurses will be graduated in 1950. The problem of the cost of nursing education and its regulation is also spread over the cost per bed daily for the individual patient.

The development of the use of the X-ray has been an equally significant feature of modern medical practice. In some institutions, poorly trained assistants called technicians operate X-ray equipment. Only the physician is licensed by the state to practice medicine. It has seemed to us that nothing less than the training of a physician is sufficient for the one who bears the responsibility of direction and conduct of any laboratory. The clinical laboratory deals with the clinical microscopic examination of materials from the bodies of men and X-ray laboratory with men. X-rays are a force potential for danger as well as for good. Fly-by-night X-ray laboratories devoted to diagnosis, to treatment, and even to the removal of excess fat have sprung up throughout the country. They are a menace to the public health. The person who wants safety will consult the list of approved laboratories before submitting his person to the tender ministrations of such an institution. It is quite natural that the financial aspects of the hospital problem should receive attention. The annual cost of all forms of medical service is somewhat under three billion dollars, approximately 3 per cent of our national income. The expenditures are roughly divided into: physicians, 25 per cent; hospitals, 25 per cent; patent medicines and drugs, 25 per cent; nurses, dentists and others, 25 per cent. The total sum is large but not alarming when one considers that our annual expenditures for such items as passenger automobiles, tobacco, candy, cosmetics, soft drinks, toys, jewelry and amusement total over ten billions a year, spent largely by persons of moderate means for whom the problems of adequate medical care are most pressing. The amount spent each year for tobacco is more than twice the total income of all the physicians in the country. We spend more on candy alone each year than we do for the maintenance of all our hospitals, civil and governmental. The amount spent for cosmetic and jewelry is much greater than for nurses. The public, of course, buys what it is taught to buy, and manufacturers spend a billion and a half dollars a year in that instruction by means of advertising. The public, when convinced of the value of proper medical care, should have little difficulty in financing it, although it may mean curtailing a little on expenditures for non-essentials.

The total cost of medical care is not alarming when compared with other expenditures; but totals and averages mean little, for sickness and disability are very uneven in distribution. Efforts have been made to distribute the economic load of illness and incapacity over a large fraction of the population by means of so-called sickness insurance in more than thirty countries. "Sickness insurance" is in reality a combination of indirect taxation, compulsory saving and state subsidy. No national plan of financing medical care has been developed in this country; but clinics, hospitals, industrial medicine, home nursing, school medical and nursing services, rural hospital centers, sanatoriums, community chest, philanthropy, the Veterans' Bureau and other agencies provide medical care for about the same elements in our population as "sickness insurance" does in other countries.

During the past decade there have repeatedly appeared in the public press articles purporting to convey the truth relative to the mismanage-

ment, unfairness and general heartlessness of hospitals. The majority of these pseudo writers have been willing to distort the truth concerning hospitals and the practice of medicine generally just for a means of increasing their income. They are the types out for sensational headliners in newspapers. They are the writers who will distort the truth for the benefit of the public who are slaves to the sensational.

Fortunately a number of articles have appeared, written in a truthful and less sensational manner, defending and explaining the cause of the hospital. The hospital, however, need feel neither particularly complimented nor offended at this unusual interest in its affairs.

People have made the hospital and medical profession a public utility, and it is the only institution and profession in the world that is really working for the public against disease, thereby cutting down their own income. They are constantly teaching the general public how to take better care of their minds and bodies in order to combat disease. These medical scientists and chemists are working out new treatments in medicine and the roentgen rays to combat disease.

Again there are those who claim that the heartlessness of hospitals is expressed in the prompt sending of bills and the requirement that expenses for treatment be met in advance. Every well-informed hospital superintendent is fully aware of the difficulties encountered in collecting the bills due the hospital. The charitable atmosphere in which the hospital is rightfully enshrouded is often interpreted by dishonest persons as an invitation to endeavor to defraud the institution, and this they do with apparent ease of conscience and with the usual immunity from prosecution. They forget the very existence of the hospitals is dependent on the payment of charges for services and the benefits that the hospital has made possible for its patients.

A superintendent does not easily convince himself that a suit for payment of hospital bills is a wise move. And yet is there any valid reason why it is more undignified or unethical for a hospital to collect its bills promptly than it is for a commercial house to do so? Unless the latter adopted such basic business principles, it would soon find itself in the hands of a receiver. No hospital, however, ever refuses its care to the sick or injured who really need its services when they are truly unable to pay. That the expense of hospitalizing the sick is exhorbitant is a further charge brought against the hospital of today. The Modern Hospital magazine made a study of 100 hospitals scattered over the country and proved that ten thousand full pay patients paid seventy-two dollars for an average treatment of eleven days each. Keeping up with the Joneses is the principle cause of unnecessary expense of patients demanding private rooms and special nurses, when they could be just as well taken care of within means of their income in wards, cared for by general duty nurses. All people should know there are many diseases which formerly made up a great portion of our sickness and causes of death, which no one need have now. Some of these are: scarlet fever, diphtheria, smallpox, dysentery, and typhoid fever. Vaccines and serums are now almost one hundred per cent sure proof against these. Consult your hospital and find how you and your children may benefit from these advances of medical science. There are medical precautions now that protect us against malaria, tuberculosis and hook-worm. Many who may hear this broadcast won't believe that the last three diseases named, annually reduce the earning power of the working class of Florida by twelve million dollars. If the people of Florida will get acquainted with their local hospitals or consult their family physicians the physical and economic loss from these diseases will be much reduced and finally eliminated.

You go to your dentist twice a year. Why not go to your family physician and have a thorough physical examination at least once a year. Then make a trip to the laboratories of your community hospital, and have your blood checked up, your heart action examined, your lungs X-rayed, and your kidneys thoroughly examined, the building up and breaking down process of your body gauged, should your physical examination reveal the need for any or all of them. All of these are precautions and security against possible inroads of malignant disease, loss of happiness and impairment to and of the public in general. Your hospitals have these benefits for you, for the asking.

Our own state of Florida has eighty-two registered hospitals and an adult capacity of 8,159 beds and 479 bassinets for infants. Get acquainted with your hospital. May 12th is National Hospital Day. It is also the anniversary birthday of Florence Nightingale, the great nurse of the Crimean War, who did so much good for humanity.

On behalf of the American Hospital Association and the Florida State Hospital Association I extend a cordial invitation to visit your hospital May 12th and get acquainted with your life saving station, your community's greatest asset, truly the house by the side of the road where flows the milk of human kindness.

STATE NEWS ITEMS

Honoring Dr. and Mrs. J. A. Strickland of St. Petersburg on their twenty-first wedding anniversary, a group of their friends surprised them with a house warming and Valentine party on February 14th at their new home on 19th Ave. N.E. Dr. and Mrs. Strickland were presented with a gift from the group following an informal musical entertainment by Dr. Prescott LeBreton and Mrs. O. F. Tiffany. Refreshments were served by the guests.

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Dr. J. F. Binkley of West Palm Beach was one of the winners in a blind bogey play held at the Belvedere Country club the latter part of February.

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Dr. Daniel L. McSwain, who for many years has practiced in Arcadia, died Saturday morning, January 28th. Dr. McSwain was vice-president of the Board of Directors of the Arcadia General Hospital.

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Dr. and Mrs. Harold E. Miller, who were married on February 9th in Savannah, Ga., have returned to New Smyrna after a brief wedding trip spent in southern Florida.

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Colonel H. A. Day of Orlando, a member of Governor Sholtz' staff, attended the inauguration of President Roosevelt in company with the Governor.

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The case of Tyree C. Whitehurst of Tampa, who was charged with practicing medicine illegally and who has been in the courts on several occasions, was finally terminated in the Federal District court, March 8th, when the jury brought in a verdict of "guilty."

The second count in the indictment against Whitehurst was using the mails to defraud in that he sent to the State Board of Health an application for a certificate of registration. The State Board of Health representative exhibited the original application together with the envelope in which it was sent through the mails and testified accordingly. It will be interesting to the doctors of Florida to know that the annual registration of those practicing the healing arts has been useful in securing a conviction of one who attempted to practice illegally.

According to the newspaper, Judge Akerman is quoted as stating the following in pronouncing sentence: "I have always tried not to hold an antipathy toward any individual. We are human, however, and I have an antipathy toward certain individuals. I have been informed that Whitehurst is a professional abortionist, and I am going to place him where he cannot practice his nefarious business. Personally, I think the profession of medicine, the calling of a doctor and physicion, is greater than that of the ministry."

Among those subpenaed on the case were: Dr. Wm. M. Rowlett, secretary of the State Board of Medical Examiners; Dr. T. D. Vassar, Lakeland, formerly president of the State Board of Medical Examiners; Dr. E. W. Warren, formerly secretary of a District Board of Medical Examiners; and Stewart Thompson, director of the Vital Statistics Bureau, State Board of Health.

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Dr. Gerry R. Holden, Jacksonville, president of the Florida Medical Association, was elected president-elect of the Southeastern Surgical Congress held in Atlanta, March 6th. Other members of the Association who were in attendance were: J. C. Davis, Quincy; A. W. Knox, Sanford; Kenneth Morris, Jacksonville; J. Knox Simpson, Jacksonville; J. S. Turberville, Century; Harold D. Van Schaick, Jacksonville; Frederick J. Waas, Jacksonville; and J. Ralston Wells, Daytona Beach.

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Dr. A. B. Connor, general chairman of the Broward County Medical Society (the entertaining society) has been calling regular meetings of his committees in preparation for the Sixtieth Annual Meeting of the Florida Medical Association. On Monday, February 20th, Dr. Connor called together all of his committee chairmen to meet with Stewart Thompson, the business manager, in planning a financial budget and necessary expenses that will be incurred during the convention. The committees are very enthusiastic and have been working diligently on the responsibilities delegated to them.

The twenty-ninth Annual Congress on Medical Education and Licensure was held in Chicago, February 13th and 14th. Participating in the Congress were the Council on Medical Education and Hospitals of the American Medical Association, the Federation of State Medical Boards of the United States, American Conference on Hospital Service, and the Council on Physical Therapy of the American Medical Association.

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Dr. G. H. Edwards of Orlando spoke before the Orange County Health Council in February, taking as his subject, "Protection."

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The regular quarterly clinical meeting of the Florida Dermatological Association was held at Miami the week-end of February 12th. Those attending the meeting were Alan Brown, J. Frank Wilson, J. Lee Kirby-Smith of Jacksonville; C. A. Andrews and J. J. Saxton of Tampa; and R. M. Faver, Joseph Stewart, J. W. Shisler, Rothwell Lefholz, G. N. MacDonell and Elmo D. French of Miami. An exhibition of unusual skin cases was held at the Miami City Clinic.

Dr. Jack Halton of Sarasota was one of the initial speakers in a campaign under way in that locality to urge people to pay their school taxes in order to avoid the closing of schools.

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The Executive Committee of the Association has announced a change in the date of the annual meeting at Hollywood. According to the present plan, the meeting will begin at 1:30 p. m., Tuesday, May 2nd, instead of on Monday, May 1st, as previously announced. See editorial this issue.

* * *

The following doctors have affiliated themselves with organized medicine through their respective county societies and the Florida Medical Association:

Charles C. Born, Pensacola
John Dees, Miami
Don C. Eskew, Miami
Donald F. Gowe, Miami
S. C. Harvard, Brooksville
S. G. Kennedy, Pensacola
Edith P. Mols, Tallahassee
Frank O. Nichols, Miami
J. G. Thames, Milton

Change in Time of Annual Meeting at Hollywood

First Session Begins 1:30 p.m., Tuesday, May 2nd, 1933

See Editorial This Issue

At the January meeting of the Victoria Hospital staff, Miami, Dr. John Milton was elected president and Dr. F. A. Vogt, vice-president. The following doctors were elected to membership: Louise DeVore, Eugene C. Lowe, Geo. McDonell, Robert T. Spicer and Arthur Woods.

* * *

The Committee on Public Relations announces the following broadcasts have been given over Station WRUF, Gainesville, under the auspices of the Association:

November 20—"Smallpox."

December 4—"An Unfinished Story—the Control of Tuberculosis."

December 18—"Cancer as a Problem of the Public Health."

January 8—"Lister and the Development of Surgery."

January 22—"Fermentation and Disease."

February 5—"The Lame, the Halt and the Blind."

February 19—"Medicine and Colonization."

March 5—"The Reduction of Infant Mortality."

The following articles, which were prepared by members of the Association, have been released to the newspapers of the State:

December 7—"Hoarseness."

December 27—"The Tonsil Problem."

January 7—"Diet."

January 24—"Creeping Eruption."

March 7—"The Case of Junior Willis."

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Dr. Ralph E. Stevens of Sanford has been named a member of the staff of the Veterans' Administration Hospital recently opened at St. Petersburg.

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Dr. and Mrs. James L. Boone of Jacksonville announce the birth of a son, February 7th.

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Dr. and Mrs. G. C. Rankin of Tampa were recent visitors at Zephyrhills.

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Dr. C. C. Collins of Jacksonville suffered the loss of a bag containing medical instruments recently while he was attending a meeting of the school board in that city. The bag was taken from his car.

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Dr. S. A. Lindsey of Ft. Meade recently enjoyed a fishing trip in the Punta Gorda district.

Dr. O. G. Kendrick recently made a trip to Winter Haven, where he attended a meeting of the Crippled Children's Commission, of which he is a member.

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Dr. and Mrs. A. D. Draper of Tampa were recent visitors in Tallahassee.

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Dr. and Mrs. G. C. Tillman of Gainesville had as their guests, during the month of February, Dr. Tillman's brother and sister-in-law, Rev. O. G. Tillman and Mrs. Tillman of North Carolina.

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Dr. Edwin C. Swift, Jacksonville, was elected to membership in the American College of Physicians, at a meeting of that body held in Montreal.

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Dr. W. J. Lancaster and family of Tampa were recent visitors in Savannah, Ga.

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Dr. Robley D. Newton of Ft. Myers announces the removal of his office to Rooms 5 and 6, Earnhardt Building.

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Dr. W. T. Langley of Sanford spent several days at Lake City during the month of February.

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Dr. H. D. Clark of Ft. Pierce was a recent visitor in Alachua.

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The next annual meeting of the Medical Association of the State of Alabama will be held in Montgomery, April 18-21, 1933.

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Dr. Ralph N. Greene of Jacksonville, in an address before the local Kiwanis Club on February 22, outlined the safety program which is being conducted by the Duval County Medical Society. This program has been instituted in an endeavor to reduce the number of automobile accidents which have increased from year to year.

* * *

Dr. Leroy H. Oetjen of Leesburg recently announced his removal to Perkin and Herndon streets.

* * *

Dr. Earl McRae of Tampa recently had as his guest Congressman Hardin Peterson of Lakeland.

Dr. H. V. Weems of Sebring recently addressed the Tourist Club of that city. His subject was "Blood Pressure."

* * *

Dr. M. H. DePass of Gainesville was a recent visitor at Baltimore, Md., where he was the guest of Dr. Howard A. Kelly.

* * *

Dr. and Mrs. Leland F. Carlton of Tampa were recent visitors at Wauchula.

* * *

Dr. J. M. Hartley of Hollywood has returned from a visit of several weeks in Atlanta.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held March 3rd, at the Huntington Club Rooms, the following scientific program was given:

"A Suggestion Regarding the Treatment of Complete Suppression of Urine, as in Bichloride Poisoning"—Carleton Deederer.

"The Present Influenza Epidemic, with Discussion of Complications"—Raymond Graves.

"Sensory Aphasia with Demonstrations of Case"—P. L. Dodge.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

Members of the DeSoto-Hardee-Highlands County Medical Society met at the Hotel Simmons in Wauchula, Tuesday evening, February 14th, for their regular meeting. A delicious turkey dinner was served to a large attendance.

Drs. J. C. Vinson and H. O. Brown of Tampa were guests of the Society and participated in the scientific session which followed the dinner.

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society, at a recent meeting, approved the following resolutions which were submitted by its Committee on Medical Economics:

CONCERNING CERTAIN MEASURES HAVING TO DO WITH CHILD HEALTH AND PROTECTION

1. The Committee on Medical Economics of the Duval County Medical Society recommends to the Society the following resolution for adoption:

Whereas, it has become well established that certain communicable diseases, among which are smallpox, diphtheria and typhoid fever, can be largely prevented by appropriate inoculations, and

Whereas, the degree of protection to the community as a whole is in proportion to the number of individuals so protected,

Be it resolved, That the Duval County Medical Society heartily endorses the universal protection of infants and children against those communicable diseases for which effective and practicable prophylactic measures exist, and that to secure this end this Society favors the enactment of legislation which shall make compulsory, as a prerequisite to admission to the public schools of this State, the immunization of every child, in so far as this is practicable, against the aforesaid diseases.

2. The Committee on Medical Economics recommends that this Society instruct its Committee on Public Health and Legislation to investigate and report upon the laws and practices of other states with respect to such protective measures.

3. The Committee on Medical Economics recommends the following resolution for adoption:

Whereas, as emphasized by the White House Conference on Child Health and Protection, "advanced tuberculous infection among school children is one of the gravest problems of school hygiene, since the lesions that are frequently followed by fatal disease occur in adolescent children and are the precursors of much of the tuberculosis of early adult life," be it, therefore,

Resolved, That the Duval County Medical Society heartily endorses the application of effective practicable measures, including adequate tuberculosis registration, designed for the early detection of clinically manifest and grave latent tuberculosis among school children.

4. Whereas, the detection of clinically manifest and grave latent tuberculosis in school children requires a staff adequately trained in the use of highly technical procedures not infrequently involving repeated examinations, and whereas the control of tuberculosis among school children requires the cooperation of public health agencies and of private physicians, the Committee on Medical Economics recommends that this Committee, in conjunction with the Committee on Public Helath and Legislation investigate the problem of tuberculosis control among school children with a view to determining the most effective and practicable means for its solution.

Whereas, It has not been an uncommon occurrence in the past for physicians practicing in our

various hospitals to find special nurses called on their cases without their knowledge, even some times when the financial resources of the patient were insufficient to meet those obligations to the hospital and the attending physician already incurred; and

Whereas, It would seem an injustice to the attending physician when the patient's resources are insufficient to meet even his fees to allow further expenditure, even by third parties, for special nursing except as necessary for the successful handling of the case; and

Whereas, The control of any case and its requirements should rest in the attending physician,

Therefore be it resolved, That the Duval County Medical Society make it known to the various hospitals of Jacksonville that no special nurses are to be called on cases without request of the attending physician, and that it is the opinion of the Society that no special nursing should be allowed on any service or charity case so long as it remains in that category.

Whereas, The Committee on Medical Economics is of the opinion that the public is entitled to be better informed as to the principles and objects of Organized Medicine, and

Whereas, We believe a large number of people are being misled by manufacturers through printed and radio advertising worded in such a manner as to lead the public to believe that their products are endorsed by the medical profession in general, to increase their sales, and

Whereas, We believe this type of advertising is an injustice to the public and an economic loss to the physician, and

Whereas, We believe the quack is using this same form of advertising solely for his financial gain and at the same time doing the public a great injustice and causing an economic loss to the ethical physician, and

Whereas, We believe that advertising is a great medium by which the people may be correctly informed as to the principles and objects of ethical medicine, and that this information would be a benefit to the public and an economic gain to the medical profession, therefore

Be it resolved, That the Duval County Medical Society begin a campaign of advertising in the local newspapers as often as finances will permit, these advertisements to be a short discussion of subjects of an educational and constructive character, to be determined by the Publicity Committee, over the signature of the Duval County Medical Society.

Whereas, The medical profession is keenly interested and involved in the expenditures of the national, state and city governments and especially the national government in relation to its expenditures for medical service to war veterans, and we are particularly involved in the extensive hospitalization of veterans whose illness is in no wise connected with war service and who are being cared for, causing a tremendous loss to the general practitioner and to the general hospitals,

Be it resolved, That we endorse the work of the National Economy League who are vigorously fighting for reduction of government costs and further, that the Committee on Medical Economics of the Duval County Medical Society desires to cooperate with the National Economy League in every way possible. A local unit of the National Economy League is in process of formation and should have the whole-hearted support of the medical profession and citizens at large.

Whereas, It is common practice for insurance companies to write physicians and ask for information relative to the health of former or present patients or the type of operation performed and its results, and

Whereas, This information is of benefit to the insurance companies principally, and only secondarily to the erstwhile patient, and

Whereas, It frequently entails a search through the physician's records, and sometime of the hospital records as well, and takes up the physician's time, and

Whereas, This information is sought gratis or, at most, for a very insignificant fee, and the physician is placed in the position of being discourteous to his patient should he refuse this information, and

Whereas, If the Medical Society should instruct its members to refuse such information without an adequate fee, the patient would understand that it was a general rule which could not be abrogated and would therefore not be offended at the physician's refusal to furnish such information gratis, therefore

Be it resolved, That the Duval County Medical Society go on record as being opposed to this arbitrary position of the insurance companies, and that it instruct its members that such infor-

mation must be recompensed by a minimum fee of $5.00 or the information shall be refused.

HILLSBORO COUNTY MEDICAL SOCIETY

Professor Rudolph W. Holmes, Professor of Obstetrics, Northwestern University of Chicago, was guest speaker at the meeting of the Hillsboro County Medical Society, held February 7th. Dr. Holmes presented a paper on "Cesarean Section."

LAKE COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Lake County Medical Society was held at the Fountain Inn Hotel, Eustis, February 25th, at 7:00 p. m. The guests of honor were Dr. Gerry R. Holden, Jacksonville, president of the Florida Medical Association, Dr. Shaler Richardson, Jacksonville, secretary of the Association, and Drs. G. H. Edwards and Meredith Mallory of Orlando. Dr. Holden spoke on "Medical Economics" and Dr. Richardson described the functioning of the State Medical Association and the publication of the Journal. About sixteen members were present. Dr. H. H. Hannum presided at the meeting.

ORANGE COUNTY MEDICAL SOCIETY

The February meeting of the Orange County Medical Society convened in the lounge of the Orange General Hospital on Wednesday, the 15th, at 8:30 p. m., with Dr. Hewitt Johnston in the chair. Very interesting papers were read by Dr. Rosalie Slaughter Morton on "Arthritis" and by Dr. Meredith Mallory on "The Costs and Ethics of Medical Care." Both provoked considerable discussion, that by Dr. T. M. Rivers of Kissimmee on the "Chemistry of Arthritis and the Relationship of the Histamines to Congestion in General" was unusually well presented.

A committee consisting of Drs. Chappell, Day and Gray was appointed to present the status of the physician in court, regarding subpoenas, testimony, coroner's inquests, etc.

A committee consisting of Dr. Christ, Shoemaker and Butler was appointed to confer with the executive committee of the Florida Health Association to see if there was any common ground upon which the physicians of Orange County and that group of pseudo-philanthropists could meet.

Two motions were made which caused considerable discussion: first, that the Orange County Medical Society be incorporated; second, that the surplus fund of the Society be invested in some good Government security. Both carried.

PALM BEACH COUNTY MEDICAL SOCIETY

The Palm Beach County Medical Society was addressed by Dr. J. W. Snyder of Miami at its January meeting. A discussion of goiter was followed by the demonstration of post-operative cases.

POLK COUNTY MEDICAL SOCIETY

The February meeting of the Polk County Medical Society was held at the Morrell Memorial Hospital, Lakeland, with thirty-two members present. Following a dinner, there was a brief business meeting.

Dr. A. J. Harness, formerly of Chelyan, W. Va., now located at Lakeland, was elected to membership in the society. Dr. Walter Weed introduced the honor guest and principal speaker of the evening, Dr. Gerry R. Holden, president of the Florida Medical Association. Dr. Holden gave an interesting talk on varied subjects. He called attention to the new Constitution of the Association which will be voted upon at the annual meeting to be held in Hollywood in May. Another item of interest was the announcement of a post-graduate course embracing all the major fields of practice, to be given at the University of Florida in June. Dr. Holden closed with a discussion of the Report of the Committee on Cost of Medical Care and gave some practical applications of its recommendations.

Dr. Stewart Thompson, business manager of the Association, who was also a guest of the Society, made a brief talk on the affairs of the organization.

VOLUSIA COUNTY MEDICAL SOCIETY

The February meeting of the Volusia County Medical Society was held at the Alba Court Inn, New Smyrna. Dr. M. J. Myres of Daytona Beach read a paper on "Blood Pressure."

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

THE WALTON-OKALOOSA COUNTY MEDICAL SOCIETY HAS AGAIN BEEN PLACED ON THE HONOR ROLL. 100% DUES FOR 1933 HAVE BEEN RECEIVED FROM THIS SOCIETY. THE OFFICERS OF THIS SOCIETY ARE:

President—E. L. Huggins, Freeport.

Vice-President—S. E. Stevens, Laurel Hill.

Sec'y-Treas.—A. G. Williams, Lakewood.

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Pinellas Auxiliary

The Auxiliary to the Pinellas County Medical Society had a splendid attendance and a most interesting program at their last regular luncheon meeting at the Concord hotel, in the presentation of several papers on "Men Who Have Made Medical History."

Mrs. John Herring read a paper on Dr. Ephriam McDowell, whose historic operation on Jane Todd Crawford in Danville, Ky., inaugurated the era of abdominal surgery. Men outstanding in Florida's medical history were next discussed.

An article on Dr. John Gorrie of Apalachicola, who invented the first machine for making ice was presented by Mrs. J. B. Quicksall.

Mrs. Francis Langley spoke on Dr. J. Y. Porter, who for more than a quarter of a century was State Health Officer of Florida.

Mrs. Carl Williams discussed the outstanding work Dr. J. Q. Folmar did while superintendent of the State Hospital for the Insane.

The president, Mrs. J. A. Strickland, presided at the short business session which followed the luncheon.

Mrs. Leroy Wylie reported that the use of the Elks' auditorium had been secured for March 15, at which time Dr. J. Arthur Cramp, director of the Bureau of Investigation of the A. M. A., will lecture to the public on "Patent Medicines."

* * *

Marion Auxiliary

In February the Marion Auxiliary held a luncheon meeting at the Highlands Club, at which time the following officers were elected: President, Mrs. T. H. Wallis, Ocala; Vice-President, Mrs. L. H. Van Engelken, Ocala; Secretary-Treasurer, Mrs. LeRoy Oetjen, Leesburg.

Polk Auxiliary

The Polk County Auxiliary held its February meeting at Hotel Thelma in Lakeland, where a dinner was enjoyed.

Routine business was transacted and all were urged to attend the State meeting in Hollywood in May.

Members were present from Bartow, Brewster, Mulberry and Lakeland. The next meeting will be held in Winter Haven.

* * *

Our President

Following the death of Mrs. Walter Jackson Freeman, Mrs. James F. Percy of Los Angeles, California, became president of the Woman's Auxiliary to the American Medical Association.

Mrs. Percy was born in Nebraska but moved with her parents to Southern California when five years of age. She is an active worker in woman's organizations, especially those devoted to music and the drama.

She married Dr. Percy in 1925.

Following the A. M. A. meeting in Dallas she resolved to try to interest the Los Angeles County Medical Society in the formation of a County Auxiliary. She was elected its first president and at the end of the first year there was an enrolled membership of 474. In May, 1930, she was elected president of the California State Auxiliary.

At the Detroit meeting of the Auxiliary to the A. M. A. she was made fourth vice-president. This was followed at Philadelphia by the second vice-presidency, and at New Orleans last year she was made first vice-president.

A message from Mrs. Percy asks that this might be considered a State Year. She urges all state officers and chairmen to cooperate to the fullest with the national officers and chairmen so that the influence of the work may be multiplied, that there may be growth, consolidation and coordination, thus stabilizing all phases of our activities, that we may become more firmly established than ever in the hearts and lives of those we serve.

* * *

Our First Vice-President

Mrs. Horace J. Whitacre, Tacoma, Washington, has been elected national first vice-president and ex-officio chairman of organization, filling the office left vacant by the advancement of Mrs. Percy to the presidency.

Says Mrs. Percy: "It is a great asset to the National Auxiliary to have Mrs. Whitacre be-



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Oscar T. Johnson, *Manager*

come again a member of the National Board. She has given a remarkable demonstration of her executive ability in the organization of her own State Auxiliary and as its first president. She brings to her new office charm, wisdom and a rich experience from which we shall reap the benefits."

Our president-elect is still Mrs. James Blake of Hopkins, Minnesota, and the National Convention is to be held in Milwaukee, June 12-16.

ADVERTISERS' NOTES

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Physicians know the standards by which the efficacy of a good bactericidal agent should be judged and are, therefore, in position to appreciate the findings of research chemists who show that in developing such a preparation it is quite as necessary to consider the effect of the bactericide on animals and animal tissue as it is to prove that the product will destroy bacteria.

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THE CHILL PRODUCING SUBSTANCES HAVE BEEN LARGELY REMOVED.

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These presentations of music and interesting dramatic episodes are designed to appeal to almost every type of radio listener. The announcements emphasize that only through a sufficient number of properly trained physicians can a community expect to meet its responsibility for the care and prevention of illness and the protection of health. Impressive reasons are also mentioned as to why the use of the family doctor is a good way to keep down the costs of competent, sympathetic and understanding general medical care.

DR. RANDOLPH'S SANITARIUM APPROVED

Acting under instructions from the House of Delegates of the American Medical Association, the Council on Medical Education and Hospitals is now carrying on an investigation of conditions in hospitals for mental patients in the United States.

In the interests of this work Dr. F. H. Arestad, representative of the Council, on December 6th inspected Dr. Randolph's Sanitarium for nervous and mental cases, operated in Jacksonville by Dr. James H. Randolph, neuro-psychiatrist; and as the result of Dr. Arestad's report Dr. Randolph has been advised that his sanitarium "deserves a place with regular hospitals and sanitaria, and in the next Hospital Number of the Journal of the American Medical Association it will be listed accordingly."

This is the first inspection made of Dr. Randolph's Sanitarium; and in the absence of full data regarding same in the files of the A. M. A. it was listed in the last Hospital Number as a "related institution." Dr. Arestad's report now places it in the correct classification.

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Your family may not have a regular physician. Perhaps it's because you live in a large city, perhaps it's because you've moved recently and so are out of touch with your former doctor. Whatever the reason, if you do not now have a family doctor, get one. Do it now—do not let the health you enjoy today make you careless in providing this vital safeguard against the sickness tomorrow may bring. Find and become acquainted with the person to whom you can entrust the medical welfare of your family through the years to come.

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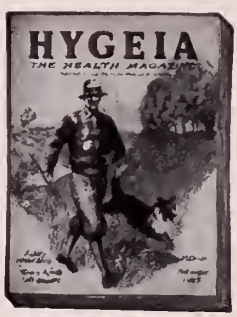
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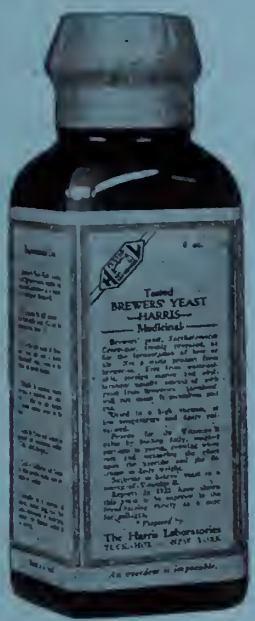
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Jacksonville, Florida, April, 1933

Yearly Subscription, $3.00
Single Copy, 30c

THE N. Y. ACADEMY OF MEDICINE
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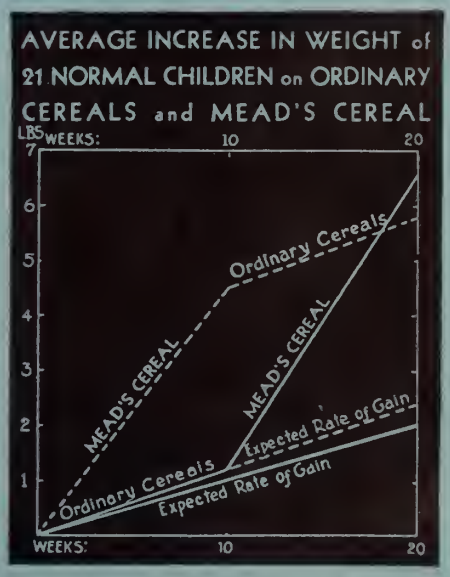
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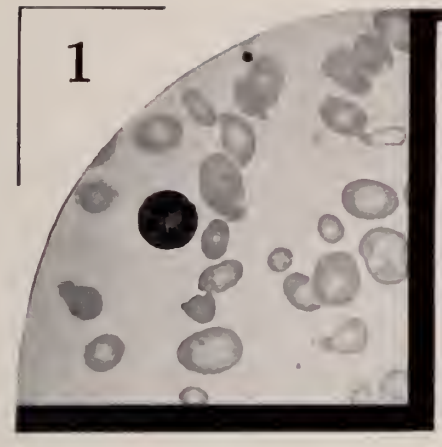
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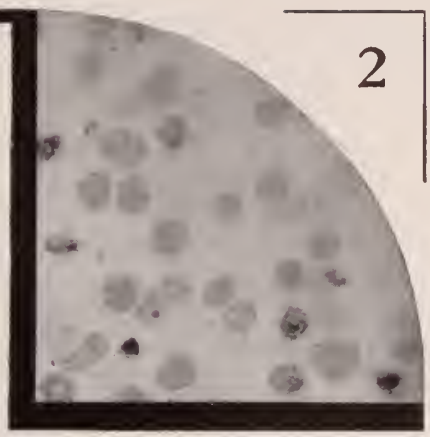
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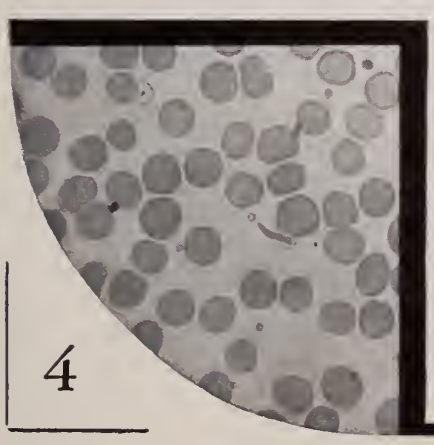
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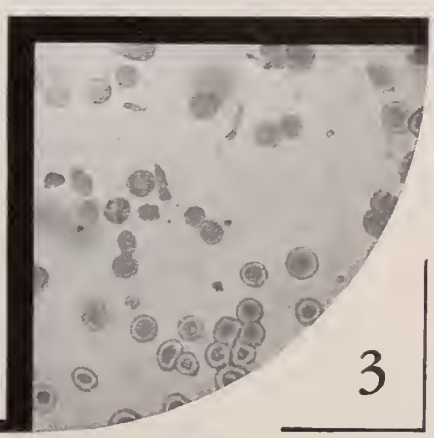
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XIX | Jacksonville, Florida, April, 1933 | Number 10

MECKEL'S DIVERTICULUM

George E. W. Hardy, M.D., F.A.C.S.,
Tampa.

On February 10th, 1931, I was asked by a local doctor to see a young woman of nineteen who was complaining of colicy pain in the lower right abdomen. She gave a history of repeated attacks of similar pain during the three years previous to her admission to the hospital. Her last menstrual period had ceased about ten days prior to admission. There was no history of leukorrhea. The patient had had no fever.

The physical examination revealed nothing important apart from the abdominal and pelvic regions. There was tenderness over the lower right quadrant but very little muscular rigidity. The point of most marked tenderness was below McBurney's point. The vaginal outlet was virginal and consequently a rectal examination was made. The uterus was of normal size and in good position. The right ovary seemed to be enlarged but could not be clearly defined. A working diagnosis was made of chronic appendicitis and cystic right ovary. The patient was ordered prepared for operation in the morning. On leaving the bedside, I remarked to my colleague that we perhaps had a case of Meckel's diverticulum but I lacked the courage to record that as the working diagnosis.

At operation, the gross findings were as follows: Both ovaries moderately enlarged and sclerotic. Two small cysts present on the left ovary. Appendix large and slightly injected. On the free edge of the ileum, about eighteen inches from the ileo-cecal valve was a small diverticulum which had a broad base and a short mesentery. At the tip of this diverticulum was a small area, about four mm. in diameter, which had ulcerated and had only a peritoneal covering.

The operative procedure consisted in removing the appendix and the two small cysts of the left ovary. The base of the diverticulum was caught between clamps and severed with the cautery and the diverticulum removed. The base was inverted by a Kerr stitch parallel to the long axis of the bowel and the line of closure was reinforced by a continuous subserous suture. The bowel was somewhat constricted after removal of the diverticulum due to the peculiar twisting attachment of the diverticulum. The patient made an uneventful recovery and has been in good health since the operation.

Meckel's diverticulum is a structure resulting from the persistence of a portion of the omphalo-mesenteric or vitelline duct. It derives its name from Johann Frederick Meckel who, in 1808, first described this condition completely and advanced the theory that it originated in the remains of the omphalo-mesenteric or vitelline duct. The alimentary canal develops from the splanchnopleure which results from the fusion of the entoderm with the inner layer of the split mesoderm. One of the earliest evaginations of the primitive alimentary canal is the yolk sac and its stalk, the omphalo-mesenteric or vitelline duct, which divides the canal into a fore and hind segment. At the end of the fourth week of embryonic life, the yolk sac presents the appearance of a small pear-shaped vesicle opening into the alimentary canal by a long narrow tube, the vitelline duct. This vesicle can be seen in the after-birth as a small somewhat oval-shaped body the diameter of which varies from one to five mm.; it is situated between the amnion and the chorion and may lie on or at a varying distance from the placenta. As a rule, the duct undergoes complete obliteration during the seventh week but according to Cunningham in about three per cent of cases its proximal part persists as a diverticulum from the small intestine. The location of the evagination of the vitelline duct from the alimentary canal would, it seems, determine whether the diverticulum contains intestinal mucosa or other congenital anomalies as gastric mucosa, immobile cecum, or aberrant pancreas. Gastric mucosa may occur in islands, or the diverticulum in rare cases may be lined throughout with it. In this mucosa may be found pyloric, Brunner's and fundus glands.

A Meckle's diverticulum is located opposite the mesenteric attachment from twelve to eighteen inches proximal to the ileo-cecal valve in the newly born up to about two or three feet in the adult, and is always single. It is a true or congenital diverticulum when the structure is analogous to

that of the bowel wall. False or acquired diverticula on the contrary have no muscular layer because this separates and allows the mucosa and submucosa to bulge through. Besides they are attached to the concave side of the intestine, lateral to the mesenteric attachment; they are often multiple and may occur throughout the bowel tract.

A Meckel's diverticulum may or may not have its own mesenteric attachment with its own blood supply independent from the bowel. It may be of any size, from a small pouch, one to one and one-half inches long and about the thickness of a small finger, to an enormous tube as in E. T. Leonard's case which was forty and one-half inches long. It is ordinarily a blind pouch but it may remain as a patent tube between its attachment to the ileum and the umbilicus. Its umbilical openings may function as an anus with a marked atrophy of the bowel below, or with both umbilicus and lower bowel discharging intestinal contents. Another possibility is that the bowel end may become occluded with the production of a sac-like tumor called a yolk cyst or enterocystoma. Again, only the distal portion of the duct may fail to subinvolute, in which event a mucus-secreting sinus remains at the umbilicus. When the entoderm of the duct alone disappears and the mesodermal covering persists, a fibrous cord passing from the ileum to the umbilicus is left. At times, for some unexplained reason, the distal part of this cord is detached, which may remain free or be attached to the mesentery or to some hernial opening predisposing to some future obstruction. Outpouchings of the mucous membrane may be the only remains of the vitelline duct, even forming definite polyps which are bright red in color and are persistent.

A Meckel's diverticulum may be present throughout life without causing symptoms. However, due to its location and construction, it is prone to cause trouble and may present a wide range of pathological problems, such as different forms of ileus, inflammatory reactions, local or general peritonitis, hemorrhage, and tumors. Halstead estimates that six per cent of all cases of obstruction are due to this anomaly. Obstruction may occur in various forms. There may be a volvulus of the diverticulum alone; or with this structure as a starting point, there may be a loop or loops of intestine involved. The diverticulum may completely encircle the bowel or by adhering to a loop of bowel, may cause the intestine to kink acutely. On account of its musculature and therefore power of contractibility, every Meckel's diverticulum is a potential menace from the standpoint of intussusception. The intussusception may end with its invagination into the bowel; or this invagination of the diverticulum, acting as a polyp, may be the beginning of a double intussusception involving the entire ileum distal to this place and extending down into the colon. In this type of intussusception, blood is often not found in the stools because the inverted diverticulum acts as an efficient plug completely closing the intestinal lumen.

Diverticulitis may result from foreign bodies and other material lodging within the lumen of the diverticulum resulting in infection of stagnating intestinal contents through stasis. Pressure necrosis and perforation are thereby produced. A thrombosis, obliterative endarteritis, or some mechanical factor may affect the blood supply and cause a similar result.

Benign and malignant tumors may develop in the wall of the diverticulum but they are relatively rare. Leiomyomas are the most likely to occur because they bear some peculiar relationship to the developmental malformation of a Meckel's diverticulum.

Tuberculosis of this anomaly is rare but when it does occur it usually is of the enteroperitoneal type which selects the cecal region, involving also the adjacent peritoneum, mesentery, and lymph glands.

Meckel's diverticulum complicating a hernia was first reported by Littre in 1770. The diverticulum may be alone in the hernial sac or it may be associated with intestine. It seems for some peculiar reason to most often involve femoral hernias.

All diverticula containing gastric mucosa have a tendency to form ulcers. Every diverticular ulcer forms at the junction of the gastric and intestinal mucosa; that is, at a point where the acid secretion comes in contact with the alkali-secreting intestinal mucosa. According to Green, writing in the November, 1930, number of the International Surgical Digest, the ulcer formed is similar to the peptic ulcer. It tends to bleed and to perforate. It is due to digestion of the intestinal mucosa by the highly acid secretion. All cases in which bleeding or perforation takes place contain gastric mucosa in more or less extensive areas in the lining. Ulcers of this type do not tend to heal, and perforation sooner or later takes place. Perforation may occur at the time of the bleeding or at a much later date.

Of the 85 cases reviewed by Green, 64 were

males and 21 females. As to age, 18 were 3 years or less, 31 were between 3 and 16, 16 were over 16 and under 25, 11 between 25 and 40, 6 between 40 and 50, and there were 3 over 50. The oldest patient was 67. In this group there were 8 cases of diverticulitis with gangrene; 1 case of traumatic rupture; 11 cases of varying types of ileus; 13 cases of bleeding ulcer with or without perforation; 14 cases of intussusception; 4 cases of diverticulum in hernial sac; 5 cases of tuberculosis of the diverticulum; 1 cyst; 1 tumor; 1 foreign body in the diverticulum; and 9 cases of umbilical trouble resulting from the diverticulum such as polyps, persistent sinuses, and discharging navel. There was associated tuberculosis in each case of diverticular tuberculosis.

From these figures, you will see that the majority of the cases occur in children and young adults. Hudson and Koplik, writing in the April, 1932, number of the New England Journal of Medicine, report 32 cases of Meckel's diverticulum occurring in children. They are of the opinion that hemorrhage from the intestinal tract as an important sign in disease of Meckel's diverticulum has not been stressed as much as observation in this series would indicate desirable. Seventeen of their thirty-two cases showed hemorrhage either with or without other signs. Of the thirty-two cases presented there are pathological reports on twenty-three. Of this number, 12 or 52% showed gastric mucosa; 6 of the remaining 11 were lined by mucosa of the small intestine, two by that of the large intestine, two could not be distinguished, and one had been completely destroyed in an inflammatory process. Three of the diverticula lined by gastric mucosa also showed a muscularis of three layers similar to that seen in the stomach, which was easily differentiated from the thinner two-layered muscularis of the adjoining intestinal portion. In one of these cases, there was an accessory pancreas in which no islands of Langerhans were seen.

The differential diagnosis of Meckel's diverticulum is difficult except in the severe cases with hemorrhage and perforation. All cases diagnosed as subacute or chronic appendicitis coming to operation should have the distal three feet of the ileum explored. Hemorrhage and perforation are the essential symptoms of this disease. Diverticular ulcer is a disease of childhood and appears at a time of life when gastric ulcer is practically non-existent. Two of the cases on record are those of nurslings who evidenced the first hemorrhage at five months. As a rule, the child begins to pass blood in full health, in some cases after having complained for some time of abdominal pain. In intussusception, blood is as a rule passed in small quantities and is intimately mixed with mucus, while in diverticular ulcer the blood is very abundant and in a state of purity.

The treatment of a Meckel's diverticulum is surgical. Usually simple excision is done, although Kleinschmidt advocates intestinal resection in order that no gastric mucosa may be left.

In conclusion, I wish to stress two facts: First, suspect a Meckel's diverticulum when you have unexplained bleeding from intestinal tract of a child, especially a male child. Second, when operating for a subacute or chronic appendicitis in an adult, form the habit of exploring the terminal three feet of ileum.

CANCER OF THE CERVIX*

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Cancer of the cervix has received the least attention of physicians, nurses and the public of any of the common forms of cancer.[2]

A woman will pay immediate attention to any kind of skin blemish and will consult a physician in time to be cured before cancer develops.

She keeps her teeth clean and smooth, consults her dentist frequently and her physician if she notices a lump, ulcer or growth on her jaw or gum and will have all defects corrected, thereby preventing the possibility of cancer.

There has been a great deal written and said about cancer of the breast and women have been taught to consult the family physician as soon as they discover a lump in the breast. If this is properly treated by radium, X-ray or surgery, as the case may require, cancer may be prevented or cured. Very few cancers of the breast ever reach the incurable stage.

Dr. Floyd E. Keene, Philadelphia, reported 475 cases of cancer of the cervix. Three-fourths of them were far advanced. Only 12% could be considered as belonging to stage one.[3]

Dr. Burnham, Baltimore, reported out of a total of 1,578 cases treated only 208, or 13.17%, belonged to the prophylactic and operable class; 969, or 61.41% were inoperable. Cures in the operable and prophylactic cases were about 50%, and of the inoperable cases 11.35%.[4]

Why cancer of the cervix is often seen by the

*Read before the Pasco-Hernando-Citrus County Medical Society, March 9, 1933.

physician too late to be cured may be due partly to the failure of the obstetrician to warn the mother of the possibilities resulting from injury to the cervix in childbirth and the importance of careful examination six to eight weeks following childbirth, to false modesty, or to some equally unpardonable reason. The fact remains that the percentage of cures of cancer of the cervix is entirely too small.

Cancer of the cervix usually occurs in women who are near, at, or beyond, menopause. Scarred lacerations of the cervix, eversion of cervical lips, extensive erosions, cervical strictures which obstruct normal drainage and persistent, infectious, leukorrheal discharges are frequently the cause of cancer of the cervix.

The primary growth on the vaginal portion of the cervix has no site of predilection; it may begin in any chronically irritated area on either the anterior or the posterior cervical lip. It tends to necrose, ulcerates extensively and exudes a serosanguinous or bloody discharge. While not infrequently we find a vaginal discharge with a distinctly "cancer odor," it is not pathognomonic of cancer, but is due to the presence of pathogenic bacteria. However, this should be a warning sign and always call for immediate and careful examination, for, if untreated, the chronic irritation from this discharge will predispose to cancer.

Hemorrhage from a woman definitely beyond the menopause is to be regarded as definite evidence of cancer until thorough examination demonstrates conclusively that no malignancy exists. Cachexia, loss of weight, pain, offensive leukorrheal discharge, enlargement of inguinal glands, swollen limbs are symptoms of minor value as they are usually late manifestations of the disease and the patient is already beyond help when they occur. A somewhat enlarged cervix, extension by infiltration of the adjacent vaginal wall, the degree of fixation of the broad ligament are of the utmost importance; however, one must take into consideration possible inflammatory thickening associated with cervical ulceration as well as residual infiltration resulting from former pelvic infection, and many patients formerly considered "inoperable" may now be regarded more favorably because fixation of the uterus is sometimes due to associated inflammatory exudates. Friable tissue which bleeds easily upon palpation of the cervix is the most important objective symptom and none other equals in importance the value of this evidence. The histological examination of a small section of the cervical tissue will confirm diagnosis.

Simple excision of tissue without traumatism from squeezing or manipulating the cervix introduces relatively small risk of metastasis and several days may elapse from the time this tissue is excised for examination and radical operative treatment without danger to the patient.

The development of cancer of the cervix to a hopeless local condition may be so rapid that a few months' delay after the warning of an unusual discharge or its reappearance after menopause may spell disaster.

Drs. Lynch and Bartlett, San Francisco, state that "a cure may be confidently expected in cervical cases properly treated."[5]

The treatment is preventive, curative and palliative. Preventive treatment calls first for more careful managing and treatment of mothers at childbirth, reducing injuries to the cervix and for educating the women, especially the mothers, to the dangers of cancer and how to recognize the very early symptoms and to request periodic examinations. All injuries to the cervix at childbirth should be repaired immediately.

Curative treatment is by radium or operative removal or a combination of radium and surgery. When cancer has extended beyond any possible operative removal, radium offers the best form of palliative treatment.

SUMMARY

The cervix next to the breast is the most frequent site of cancer, but it is much less frequently recognized in the early or curable stages.

It is much easier to prevent cancer of the cervix than to cure it.

The precautions taken in dealing with potential cancer tissues in other regions are decidedly lacking as regards the cervix.

Periodic examinations of all women, especially near, at, or after, menopause, should be made and women should be educated by the physician to the necessity of this examination and until then we will continue to have a high incidence of incurable cancer of the cervix.

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THE RESPONSIBILITY OF THE MEDICAL PROFESSION IN THE CANCER SITUATION*

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Pensacola.

Statistics from all sources are demonstrating the extreme high occurrence of cancer throughout the world. The percentage of cures are unfortunately still very small. When we analyze these statistics it would seem that the occurrence is much larger than formerly. This is more apparent than real. I feel that we are recognizing cancer more readily today than we formerly were. The greater span of life that now prevails due to more efficient prophylaxis accounts also for this higher incidence, cancer being a disease of the later years of life.

Until the exact etiology of cancerous lesions is determined we cannot hope for a marked diminution in either the mortality or incidence of this dread disease. Startling advances are being made by research all over the world which is narrowing down the possible causes to relatively few. Several schools of thought, in this matter, have their ardent supporters and antagonists, but that will-o-the-wisp continues to lead investigators a merry chase. I feel that the cause will be a combination namely: a parasite which generates a toxin of low potency which does not become pathogenic until certain conditions are present in the host. In support of this contention, I feel that the tissue reactions in early malignancy simulate very closely the tissue changes of certain parasites whose toxin is of very low toxicity. As the lesion progresses changes become more marked because of the accumulated toxins of the organisms as well as the anti-toxins developed by the disentegration of tissue cells blood supply of which does not keep pace with the rapid cell proliferation.

I am of the opinion that this parasite will be in the class of ameba.

I feel that all of us are exposed to infection by this organism but that the parasite does not become pathogenic until certain body states exist. This state may be compared to the conditions which exist which allow the tubercle bacillus to become pathogenic in our bodies.

Let us hope that the solution of this most important problem will take place in the near future.

In this state of affairs it becomes the duty of the medical profession to exert every effort to curtail the ravages of this dread disease.

In our present knowledge, it is a fact that we can effectively cure a cancer that is seen early viz: when it is still a local lesion. I use the term "cure" advisedly because we really cannot cure a condition of which we do not know the cause.

However statistics again show us that the early cases are the ones which after effective treatment have not recurred either locally or as metastases after a number of years. Occasionally, reports are received of good results in later cases or even advanced cases, but they are unfortunately few, and results cannot be duplicated in similar cases with similar treatment.

With the formation of cancer clinics in the larger centers very effective progress has been made in the therapy of cancer, but the reports from the clinics show, that the average case is seen most frequently in the later stages of the disease.

A strenuous campaign of public instruction is being carried on to disseminate knowledge of the early signs of cancer to the laity, and inform them to consult their family physician at the earliest suspicious signs. This will have little effect unless the physician familiarizes himself with the early signs of malignancy and institutes proper therapy or refers the patient to some colleague equipped to render efficient therapy.

In the skin any single lesion with induration at the base should be regarded with suspicion.

In the breast any nodule should be removed for microscopic study, no matter how trivial it may seem.

Erosion or bleeding ulcerations of the cervix should receive investigation. Painless, causeless hemorrhages from the uterus shou'd at least have the benefit of a diagnostic curettage.

All of these early signs can be found by the family physician, and it devolves upon this physician to warn his patients of the possibility of malignancy and advise them to secure treatment.

Malignant lesions of the gastro-intestinal tract are probably the latest of all malignancies to be recognized. We must realize that our greatest assistance in the early diagnosis is the roentgen ray. Any chronic indigestion or so-called dyspepsia should receive the benefit of a thorough gastro-intestinal X-ray investigation. Malignancies of the colon will often assume large proportions before severe symptoms are elicited. Any bloody stool should put us on our guard as

*Read before Walton-Okaloosa Medical Society, Feb. 16, 1933.

to a possible malignancy of the distal end of the gastro-intestinal tract. Every general practitioner should familiarize himself with the use of the proctoscope and make use of it.

In conclusion, I would like to emphasize the responsibility that rests upon the general practitioner in the diagnosis of early malignancy. It is to him that we must look to bring the message of early investigation and treatment to the general public, and unless he assumes that responsibility and acquaints himself with the early signs and symptoms, the efficiency of the cancer campaign will have little effect on lowering the alarming mortality rate and occurrence. Until such time as the cause and cure of cancer is definitely determined, I can only plead for active cooperation between the general practitioner and the highly trained cancer specialist.

RECURRENT AGRANULOCYTOSIS WITH REPORT OF A CASE*

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The literature has been overcrowded during the past few years with reports of a condition unfortunately called "agranulocytosis" or "agranulocytic angina." The word "agranulocyte" means a neutrophil without granulation which appears in leukemia, so that "agranulocytosis" therefore should be an increase in those neutrophils. The condition presents a decrease in the cells of the myeloid series and sometimes an increase in the lymphocytes. The term "neutropenia" would better describe the picture, and as the etiology is still unknown it should be modified by "idiopathic" or, better, by "malignant" to denote the seriousness of it. However, usage has given us the first two terms and for that reason, and none other, they have been used in this paper.

Shultz in 1922 is given the credit of bringing the attention of the profession to this disease. At that time he reported six fatal cases that showed a leukopenia and an agranulopenia together with an ulcerative stomatitis. From the inception of this report case histories of similar conditions poured in until the literature was overrun. This led to a classification into primary and secondary granulopenia, the secondary including (1) those due to chemical poisons, (2) radiation, (3) sepsis, (4) blood diseases—pernicious anemia, aleukemic leukemia and aplastic anemia, (5) infections, measles, mumps, influenza, typhoid and malaria.

In 1930 Franke reported only three instances of recurrent cases and in 1931 Piersol and Steinfield divided the primary granulopenia into the acute and chronic, or recurrent. The question arises as to whether or not this disease, like many other blood diseases, does not have remission and if the patients are able to survive the first attack they will get better only for the time being.

The etiological factor has remained unsolved. Irradiation and neoarsphenamine were thought causative agents, but it is likely they produce the secondary type. One investigator was able to produce the blood picture in rabbits by the injection of benzene and olive oil and thinks that the benzene ring has something to do with it. Various other toxic substances have been blamed but to date nothing definite has been proven. That it is some infection is held by more investigators than any of the other causes. There have been reports that it occurs in people who have previously had a leukopenia, but this phase has never been satisfactorily worked out, or why they should have a leukopenia. It occurs more often in the female than in the male in about the ratio of 3 or 4 to 1. It is usually seen in adult life but may occur in childhood.

Pathology.

In a large percentage of the cases there is an ulceration or even a necrosis of the tonsils, pharynx and mucous membranes of the mouth. Ulceration may also occur in the digestive tract, vagina, vulva and cervix. Cultures show various types of bacteria. Lymph nodes may be enlarged but usually are not. The liver and spleen in a small percentage of cases show enlargement. The bone marrow was at first thought to show always a decrease in granulocytic cells, but in recent reports there has been demonstrated a hyperplasia of the myeloid cells when the white count has been as low as 200.

Symptomatology.

The symptoms vary considerably. The onset of the disease in the large percentage of cases is abrupt, with no previous history of ill health. The temperature rises to 103 to 105F, with chills, sore throat, general aching and difficulty in swallowing. Other cases will give a history of several weeks' duration, with a low grade fever, general malaise, headache, loss of appetite and general weakness.

*Read before Pinellas County Medical Society, Jan. 6, 1933.

Physical Findings.

The patient is more or less prostrated and looks ill. There may or may not be a pallor of the mucous membranes. This depends to a large extent upon the duration of the disease. The degree of inflammatory reaction in the mucous membrane of the mouth and throat differs considerably in each case. In some there is nothing but a redness of the gums, tonsils and pharynx, while in a large percentage there is present gangrene or necrosis to a considerable degree. These tissues are always very sore. There may be ulcers in other parts of the gastro-intestinal tract, and ulcers of the vulva and vagina are quite frequent. Over the necrotic area there is usually present a membrane not unlike a diphtheritic membrane. In some cases there may be multiple abscesses, and at times the skin may show petechial hemorrhages. The spleen and liver are enlarged in a small number of cases. Enlargement of the lymph glands occurs in about one-half of the cases in the regions draining the mouth and pharynx.

The blood picture is the most characteristic part of the disease. There is a marked leukopenia which rapidly progresses until the count gets as low as 100 cells per cubic millimeter. The granulocytic cells decrease and in some counts one will find none at all. The red count varies, in most cases being normal, or nearly so, while it may drop in patients that have been ill a long time.

In the differential diagnosis one must differentiate from the following: (1) typhoid—here the onset is more insidious and leukopenia not so marked and there is a positive blood culture or Widal, with also a slow pulse; (2) aleukemic leukemia—there is more of a tendency to hemorrhage, the anemia is more marked and there is usually present abnormal leukocytes; (3) aplastic anemia—there is marked blood destruction both of white and red cells, with hemorrhages; (4) influenza—there may be a leukopenia but not a decrease in the granulocytes; (5) infectious mononeucleosis shows a more marked and generalized enlargement of the lymph glands and more definite spleenic enlargement; the granulocytes are not so markedly decreased.

The treatment has been unsatisfactory. Transfusion, X-ray, radium, drugs as mercurochrome, gentian violet, etc., intravenously, all have been to no avail. Liver and different vaccines have been used unsuccessfully. At present there is some evidence that nucleotide is helpful, and there have been a number of reported cases of cures, but it is too early to be sure, for it may be that the case is merely having a remission.

CASE REPORT

F. R., age seven, was brought to my office August 10th, 1931. She was seen by her local physician two weeks previously for a pain in her right hip. Four days before it was discovered she had a fever but her mother stated that she had not been well for two months, and she had complained somewhat of sore mouth. Her family history was negative, there being one child older and one younger. The only thing in the past history was the fact that a year previously a snake had bitten her and the family wanted to blame the present illness to that. She had mumps at 4, chickenpox at 5, and so-called "intestinal flu" at 6. Her temperature was 100:4, pulse 124. Physical examination was negative except for a very red throat, which was sore, and a palpable liver. Stools were negative. Blood count 2,240,000—8,200, with 53% polys, 40% small lymphocytes, 6 large and 1 esinophile. She went home but continually grew worse and on August 25th she was sent to the hospital, the white count then being 3,700 with 4% polys, and 96% small lymphs. She seemed so prostrated that it was thought best to give a blood transfusion, and 200 cc. of the father's blood was given directly. On August 27th, she was given 190 cc. On August 28th, the blood count was 4,000, with 3% polys, and 97% small lymphs. On August 30th she was given 100 cc. whole blood by direct transfusion and the next day her white count was 3,000 with 4% polys and 94% small lymphs, and 2% large. On Sept. 2nd, 100 cc. of whole blood was given directly, and the next day the white cell count dropped to 2,600, with 6% polys, 92% small, and 2% large lymphs. On Sept. 5th she was given 300 cc. of whole blood directly, and on Sept. 8th the white cell count was 390. On Sept. 9th, she had a severe chill for some unexplained reason. During this time she gradually lost ground. The temperature was between 104-105F. On Sept. 11th, the white count was 310. There was noted at this time an inflammatory reaction of the labia and some whitish discharge. She also complained of pain in her abdomen. She gradually became more apathetic and it was thought that she could not possibly live more than a day or

two. A red area appeared on the right shoulder, and on Sept. 12th, the temperature reached 106:2. There appeared on back and shoulder several small abscesses. On Sept. 13th, the father was given a stock vaccine for colds, and on Sept. 14th, 100 cc. of his blood was injected intraperitoneally. The next day the white count was 700, and the following day 1,300. On Sept. 18th, the procedure was repeated, the father on the previous day having been given the "cold" vaccine, with the result that on the following day the count was 2,000 with 53% polys, 39% small and 8% large lymphs. The patient appeared better, and the temperature began to come down. On Sept. 21st, she was able to be up. Sept. 26th, another 200 cc. was given intraperitoneally, following the vaccine to the father. On Sept. 29th, she was discharged with a white count of 5,900, 52% polys, 44% small and 4% large lymphs. The family was advised to have her tonsils removed in the near future. She was seen off and on during the ensuing weeks, with the following blood counts:

Oct. 28, R. 4,032,000, W. 4,750, 24% polys, 30% sm., 46% large.

Dec. 29, R. 4,880,000, W. 6,700, 32% polys, 25% sm., 43% large.

On Jan. 25th, she came to the office, having been sick for three weeks. The count then was 4,500 white cells, 23% polys, 51% small and 26% large lymphs. That day she had a fever of 100:4.

During the following month she seemed to improve, except that the polys gradually disappeared, and the matter of tonsillectomy was pressed upon the family. On March 9th, she was admitted to the hospital and given 200 cc. of the father's blood, he having had the vaccine the day before. Her blood count at this time was R. 4,200,000, W. 7,350, 2% polys, 82% small and 16% large lymphs. On March 11th, her tonsils were taken out, and in about three hours she began bleeding. The laryngologist on examination found the tissues all so friable that nothing could be done to stop the hemorrhage. She seemed to bleed into the tissues themselves. Fibrogen and transfusion were resorted to, but she died early the next morning.

Whether the vaccine given to the father had any effect at all upon stimulating the production of white cells, I do not know, but will leave it with you as one suggestion for treatment.

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SURGERY OF THE SYMPATHETIC NERVOUS SYSTEM*

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Surgery of the sympathetic nervous system marks one of the most recent advances in surgical endeavors. These efforts have resulted in a clearer understanding of certain clinical problems so that rather specific alleviation of heretofore unsatisfactory surgical efforts are now possible. Further physiological knowledge has been added, as well as new diagnostic methods, so that, at the present time, there are definite clinical indications for operating on the sympathetic nervous system and the results can be scientifically estimated before operation.

In the first quarter of the seventeenth century a symmetric form of recurring gangrene was described. In 1724 Petit noted the resulting dilatation of the pupil produced by stimulating the cervical sympathetic ganglion on the same side. It was before the rami communicantes were described that the sympathetic chain had been identified as being a part from the central nervous system. Before Langley established the differentiation between pre-ganglionic and post-ganglionic fibers, Bernard had noted the dilated capillaries, the increased heat, and the dilated pupil following the division of the cervical sympathetics in animals. Virchow demonstrated the results of thrombosis in the production of gangrene some time after Quesnay had referred to the relationship between gangrene and vascular disease. Lister, from his researches, concluded that the sympathetic system was capable of independent action, but was in strict subordination to the spinal system. About the middle of the nineteenth century Raynaud contributed his studies, demonstrating a resulting gangrene without pathological changes in the arteries. In 1878 Weir Mitchell described erythromelalgia. In the more recent years the contributions of Berger, Lerische, Hunter and Royal, Adson, Brown, Learmonth, Kuntz, etc., have brought us our

*Read before the Hillsboro County Medical Society, Tampa, Fla., September 6, 1932.

present anatomical knowledge, clearer clinical pictures, improved surgical technique, and the results in certain clinical conditions which have heretofore been more or less empirically or symptomatically treated.

The complexity of the sympathetic nervous system is more evident even with a brief description of its anatomy (Fig. 1A). This system is

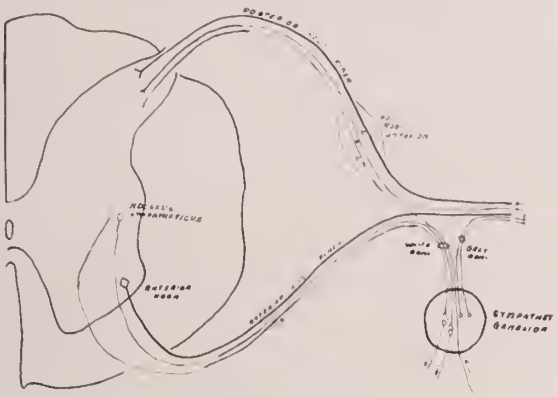
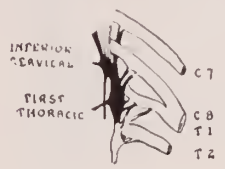


Fig. 1A. (After Purves-Stewart).
Diagram of the anatomy of the sympathetic fibers.

composed of the sympathetics proper and the para-sympathetics; though not differing anatomically, they act against each other so as to maintain a functional balance. Whereas the spinal nerve innervates its end organ uninterrupted, the sympathetic fiber has always an interposed ganglion cell along its course. Hence the so-called *pre-ganglionic* fibers which go from the cerebrospinal cells to the ganglia and the *post-ganglionic* fibers from the ganglia to the viscera, blood vessels, sweat glands, nonstriped muscles, pupils, genital organs, and the heart. With the exception of the cervical region where there are three sympathetic ganglia, there is a chain of ganglia on each side of the vertebral column with a ganglion which corresponds to each of the spinal nerve roots. The cervical ganglia are connected with the spinal cord through the first and second thoracic roots. The connection of this sympathetic chain with the spinal cord is by the short *rami communicantes,* of which there are two types, the so-called *white* and *gray rami.* The *white rami* are spino-sympathetic, being pre-ganglionic. These arise from cells in the spinal cord and emerge from the cord via anterior roots from the first thoracic to the second lumbar inclusively. These end in a corresponding sympathetic ganglion. From the ganglion the fiber is destined for its visceral or vascular termination. The white rami also contain fibers which belong to the cells of the posterior root ganglion and run through the sympathetic ganglion from their peripheral sensory organ to the posterior root ganglion. The *gray rami* carry impulses from the sympathetic ganglia to the cerebrospinal nerves and are not limited to the thoracic and upper lumbar regions. It is over these tracts that impulses for viscero-motor, vaso-motor, vaso-inhibitory, excito-glandular, or secretory activities travel.

The ganglia which are peripherally placed about the viscera supplied, namely, the cardiac, solar and hypogastric plexus, compose the main part of the autonomic division of the sympathetic system.

In this communication conditions affecting chiefly the extremities will be dealt with. The cervico-thoracic and the lower lumbar ganglia and rami are for this reason the anatomical structures of chief interest, the anatomical knowledge of these structures being the primary interest to one who is anticipating their surgical removal (Fig. 1B).



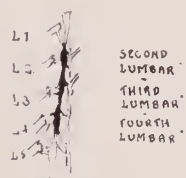


Fig. 1B.
(After Adson).
The ganglia and rami of chief surgical concern in diseases of the extremities.

The establishment of a "vaso-motor index" is most important (Fig. 2). This is a term used by Brown to designate a change in the skin temperature which is primarily vaso-motor. In the establishment of this vascular index, the production of artificial fever or some type of nerve blocking has been used. The administration of typhoid vaccine is probably the most popular method. The systemic

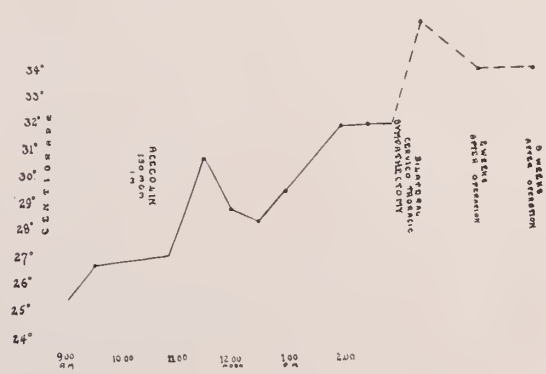


Fig. 2. Temperature studies in a case of Berger's disease showing first, the rise in skin temperatures with a vaso-dilator drug, and second, the permanent skin temperature changes after operation.

reaction with the fever test must be carefully checked, for the index is computed on a basis of the corresponding skin temperature rise. A sufficient rise in skin temperature is indicative of the amount of vaso-dilatation that can be permanently established by removal of the sympathetic ganglia and rami. Peripheral nerve blocking and para-vertebral blocking of the ganglia themselves with novocain, with subsequent skin temperature studies have been used in establishing the "vascular index." Spinal anesthesia, as well as general anesthesia, with skin temperature studies gives one a definite lead as to the amount of blood that may be put into the capillary circulation in the vaso-spastic diseases. Certain drugs which act as vaso-dilators, of which acecolin is the best known, have been used, not only for the establishment of an index but for therapeutic measures. Thus, in the establishment of the "vascular index," one has a very definite scientific basis for anticipating what may be accomplished by surgical efforts. With our present anatomical knowledge, and clearer clinical facts, the range of investigation in surgery of the sympathetic nervous system has included many empirical efforts, but there has come from the melting pot certain conditions for which there is a careful scientific basis for expecting and prognosing the results of removal of the indicated sympathetic ganglia and their corresponding rami. The influence surgery of the sympathetic nervous system in relieving the symptoms of Raynaud's disease, thrombo-angiitis obliterans, scleroderma, selected arthritic cases, Hirschsprung's disease, and "cord" bladder have been fairly well established.

Raynaud's Disease: In this disease there is an intermittant paroxysmal symmetrical vasospasm. There are no palpable changes in the pulsations of the large vessels. These patients complain of cold extremities, but it is not until definite color changes take place or pain supervenes that they consult the physician. The color changes vary from a pallor to a cyanosis. The outstanding symptoms may be pain. Though there may be a long period of paroxysms of color changes before trophic changes appear, gangrene may develop quite rapidly in symmetrical digits. The paroxysms usually begin with a tingling sensation progressing to extreme coldness and end in a dull deep pain during the periods of cyanosis. Emotional stress, excitation, or embarrassment may precipitate the paroxysms as well as environmental temperature changes.

Occurring in better than eighty per cent of the cases as a disease of females, this functional malady is more commonly seen in or about the third or fourth decade of life. The outlook in these cases depends somewhat upon the rapidity of progress of the disease during the first three years. If, after this lapse of time, there have been no trophic changes it is rarely that they will develop. Once gangrene has begun, salvaging the destroyed tissue is out of the question. Before this stage sympathectomy offers relief of the vaso-spasms, alleviation of pain, and even after gangrene has destroyed part of the digits, the disease may be arrested and further destruction of tissue prevented.

Thrombo-angiitis Obliterans: At one time thought of as a disease of the Hebrew race, this condition is more common in males and there is no particular racial selectivity. It is a disease of the blood vessels and the pathological changes are those of a low grade inflammatory process. There is present usually an associated phlebitis. In its acute stages and at the onset of the condition this may pass unnoticed for it is not the disease that produces symptoms but the subsequent obliterative thrombosis that causes the discomforts, color changes, gangrene, etc.

Thrombo-angiitis obliterans is characterized by a disappearance of the palpable pulsations of the large vessels supplying the extremity. This pulse obliteration, unlike Raynaud's disease, may vary from a diminution to a complete disappearance. Pain is usually the symptom which prompts medical advice. The pain is usually complained of as being of a deep dull character and precipitated or exaggerated by use of the extremity. When the lower extremities are involved there is a history of an inability to walk any distance before being incapacitated because of the extreme pain.

The color changes in the extremities are rather characteristic. These are made worse by exposure in cold weather or submerging the affected member in ice water. First, there is a blanching of the skin, followed by a dusky reddening developing frequently to a purple cyanosis. These color changes slowly disappear upon elevation of the extremity.

Trophic disturbances are not uncommon, varying from small ulcerative areas to extensive gangrene. These degenerative changes usually begin with small blisters which readily become infected, leaving ulcerated areas which fail to heal. Such areas may persist for a long period of time before

further changes take place. One digit may become gangrenous and unlike Raynaud's symmetrical gangrene is not always the case.

The results from sympathectomy are to be anticipated from the "vaso-motor index" studies. If the blood supply to the extremity can be temporarily increased by some vaso-dilator in sufficient amount, a study of the elevation of the skin temperature will form the basis for the advisability of surgically removing the sympathetic chain. Removing the sympathetic ganglia and interruption of the rami communicantes results in a capillary dilatation equal to or greater than that produced by the vaso-dilator administered for establishing the vaso-motor index.

Scleroderma: This is a peculiar, rather uncommon disease, more frequently seen in women. It is characterized by slowly increasing fibrosis and atrophy of the skin and subadjacent soft tissues and bones. It usually appears first in the extremities, with atrophy of the subcutaneous tissues, followed by a thickening and tightening of the skin. The hands are cold, clammy, shiny, and trophic changes are not uncommon. Cyanosis, loss of sweating, dyspnea, etc., not infrequently appear. Here again the indication for operation depends upon the response of the skin to the vaso-dilator agents.

Chronic Arthritis: In certain selected cases of arthritis with cold, clammy, painful joints, in the absence of marked bony changes, the vascularity of these painful extremities can be increased by removal of the sympathetic influence. These cases should be carefully selected and studied for their response to vaso-dilators and if the vaso-motor index is sufficient, relief of their pain, ability to get back on their feet, and a disappearance of the swelling of the joints has been noted.

Hirschsprung's Disease: This is a disease characterized by a congenital idiopathic dilatation of the colon. The symptoms are those of chronic constipation, these people going at times as long as two weeks without evacuation of their bowels. Most frequently there is a history of no normal spontaneous bowel movement. X-ray studies (Fig. 3) establish the diagnosis. Such a dilated colon may retain from four to six quarts of barium. Under spinal anesthesia intestinal evacuation will occur. Thus the diminution in the size of the colon can be studied and again one has a definite index as to what may be expected following sympathectomy.



Fig. 3. Illustrating the enormous colon of a Hirschsprung's disease.

Cord Bladder: This term has been applied to cases of painful micturition where emptying of the bladder is usually incomplete or at times impossible. There is usually some associated myelitis of the sacral cord or some allied condition affecting the lower portion of the parasympathetic system. In sectioning the presecral nerve in these cases, bladder improvement, to complete alleviation of the bladder symptoms has followed.

In summary, there are certain clinical conditions such as the "cord bladder," Hirschsprung's disease, certain vaso-motor diseases as Raynaud's, Berger's, scleroderma, and selected arthritic for which we have a definite scientific basis as to operability. There remains to be seen and evaluated, the efforts and results in angina, asthmatics, causalgias, and some of the painful gynecological conditions as to the place surgery of the sympathetic nervous system has in the treatment of these conditions.

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SYMPTOMS, DIAGNOSIS AND TREATMENT OF ILEOCOLITIS*

NATHANIEL L. SPENGLER, M.D.,
Tampa.

"We are as far from specific prevention and cure of the dysentery group as we were a generation ago. Certain hygienic procedures have done much to lower the incidence of and mortality from this group, but no real work has been done which even promises anything resembling specific therapy. This is a badly neglected field." (Royster.)

In studying the infant mortality charts over periods from five to ten years, colitis ranks among the first in mortality rate. Colitis, enteritis, ileocolitis, enterocolitis, inflammatory diarrhea, and dysentery are all terms each of which is supposed to refer to a definite pathological condition. Colitis is an infectious disease and spreads rapidly by contact, milk supply, water and flies.

Its distribution by milk has largely been checked by a better knowledge of the public in handling milk, by pasteurization in the larger centers and by immediate refrigeration until ready for consumption. Deep wells have eliminated its spread by drinking water; flies are no longer a source of danger, since screens and sanitary toilets have come into general use. The source of infection should be located, if possible, the patient isolated, and all excretions handled with the utmost care, to prevent spread to other members of the family.

It is a seasonal disease, more prevalent in summer and extending through the month of November. This is explained by the fact that bacterial infection of milk is greatest in summer, due to a lack of refrigeration. The rise and fall of infant mortality rate in summer follows the rise and fall of the bacteria count in milk supply.

The pathology of the intestinal tract ranges in degree from a slight hyperemia of the mucous membrane to extensive ulceration and invasion of the mucous membrane of the ileum and colon. There is marked dehydration of all body tissues with a rapid loss of weight.

Complications are otitis media, bronchopneumonia, nephritis, pyelitis, meningitis, in fact, almost anything may happen when resistance is lowered as much as it is in colitis.

Colitis occurs most frequently in the first two years of life and more often in artificially-fed babies. The symptoms may be mild or severe, depending on the degree of infection and the kind of organisms present. I will not go into the finer points of differentiation of the different organisms present, because we understand so little of intestinal bacteria as disease-producing organisms that I deem further discussion of little practical value.

Colitis usually begins with fretfulness, irritability, temperature, loss of appetite and vomiting, if the patient has been taking large quantities of food. The bowel movements, if of the diarrheal type, are increased with a foul and offensive odor. There is high temperature sometimes followed

*Read before the Polk County Medical Society, June, 1931.

by convulsions with characteristic facies of intestinal toxemia.

Frequently at this stage, the disease terminates and a rapid recovery results; when this occurs you can be sure you have been dealing with a case of diarrhea and not a typical colitis. Frequently, following in the wake of these symptoms is the typical blood-stained stools with large quantities of mucus. The movements are accompanied by a severe tenesmus and a whining irritable baby with dry mouth, rapid dehydration and a pronounced thirst. Temperature is not high, ranging around 102° and 103°. These cases show different degrees of severity and the amount of blood and mucus in stools is a good index of the degree of ulcerations in the intestines. If the temperature is prolonged beyond the usual time, it is suggestive of beginning complications, such as nephritis, pyelitis, otitis media, toxemia, marked dehydration and loss of appetite.

Treatment: If the patient has extremely high temperature, marked distention, vomiting, foul, offensive stools, and a great amount of toxemia, it is wise to empty the intestinal tract by giving enemas followed by the administration of some laxative suitable to the age of the child, preferably milk of magnesia. If the above conditions are recognized and handled as outlined, the period of illness will be shortened and many cases of colitis avoided. If bloody stools appear the patient should be handled as any primary case of colitis. An examination of the urine should be made following all severe cases of colitis, with repeated examinations during the attack, because pyelitis is a frequent complication.

Finklestein contributed largely to the successful treatment of colitis by the use of proteid milk. He taught that the diet in the treatment of colitis should be both fat and sugar free, but rich in protein. The fat and sugar, he taught, increased fermentation and peristalsis. Proteid milk yields a large residue by-product of digestion which fills the intestinal tract, slowing down peristalsis and giving the diseased ileum and colon an opportunity to heal, provided enough of the protein milk can be given the baby.

With my method of feeding, the child receives ample food of a good variety with a large residue of digestion, and the peristalsis is controlled by opium. This plan allows healing of the diseased mucous membrane and at the same time affords food ample for repair, waste, growth and general development, a feature that has been overlooked in other methods of feeding. Animal broths, egg albumen and barley water are of little value, because they stimulate peristalsis and do not contain enough food value and very little residue.

In older children, the same procedure can be followed, only with a more liberal diet, such as cereals, eggs, toast and sugar. Opium should be used, but astringents are not indicated. My policy is to feed these patients rather than starve them. We are dealing with a wasting disease, and the patients must have food to keep up their resistance.

The well-nourished, breast-fed or artificially-fed baby with a negative history of illness, with hard and firm muscular development will comprise the mild cases. Those patients with a more unfavorable past history, with lots of useless fat, soft and flabby muscular tone, whether breast or artificially fed, will comprise the severe cases. In the severe cases oral, rectal, and nasal feeding should be employed in the order mentioned.

Purgatives, with 24 to 48 hours' starvation period, should not be practiced in any case of colitis; the patient's strength is waning fast enough, so why add speed to it by these measures. It is only in the fermental or toxic type that these measures are indicated.

To treat colitis on a basis of stool reading alone is a mistake, because, as stated before, our knowledge is limited and grave errors are made as a result. The diet consists of whole pasteurized skimmed milk, alcoholic stimulants and water freely. Lactic acid milk in many of these cases produces a diarrhea and should be given with care. Do not give colonic irrigations.

All of us have been taught that opium in any form is contraindicated in the treatment of colitis, except that a suppository or an occasional dose may be of service. The success of this treatment is based on the increased addition of whole skimmed milk, sugar and two per cent fat, with the administration of tincture of opium and camphor after each stool from the beginning of the first symptoms of colitis to the point of producing drowsiness if necessary, to control the peristalsis and reduce the number of stools from four to eight in the 24 hours. It is best administered in drop doses, so the quantity desired can be increased or decreased and the volume of the dose kept within the bounds of usefulness by increase or decrease in the number of stools, thereby keeping the peristalsis of the intestines within the desired limitations.

Some alcoholic stimulant containing about 18 to 20 per cent alcohol given at four-hour intervals has a quieting effect on the patient and when used throughout the attack very much less opium is required. Constipation is a thing to be considered but seldom arises and then only in the latter part of the disease, when the dosage of opium is too large or continued too long. The same procedure of administration of tincture of opium and camphor is followed in older children, only the dosage is larger. The foods given to older children consist of cereals, eggs, whole milk, toast with milk, vegetable soup with milk, and well-ripened bananas with milk. The organs of digestion in colitis are not affected, so there is no contraindication to a general diet of soft foods with a large residue.

The diseased area of the ileum and colon in colitis is negligible so far as its effect on the normal absorption of food. The above diet assures a normal amount of food, thereby maintaining a correct proportion between growth, repair and waste. Under the old method of treatment with a period of fasting followed by a diet that is not life sustaining, it is no wonder that the mortality rate of colitis has not been reduced.

A PERSPECTIVE OF CANCER

D. Paul Bird, M.D.,
Lakeland.

In 1927, the vital statistics of the Census Bureau showed cancer, as a cause of death, to have advanced from sixth to fourth place and as a single cause of death, independent of any other cause, to stand alone and supreme in adult life. More recently Wood states, from a review of cancer statistics in Pennsylvania, that cancer is on an increase in that state. He bases his conclusions on a review of breast cancer which is increasing twice as fast as the population of that state. Both federal and state statistics show an increase in the death rate from cancer during the period from 1911 to 1930. These significant facts stimulate us to inquire more closely into the present scientific views on cancer.

There is not at the present time any one single agent which has been given the credit for causing the development of malignant disease. Irritation probably plays an important role when given other favorable conditions. Such precancerous conditions may consist of pigmented moles, warts, senile keratosis, chronic ulcers, fissures, erosions, lacerations of the cervix, chronic cystitis, prostatitis, leukoplakia of the vulva, involution changes, and benign tumors in later life. Again benign tumors become malignant from no apparent cause. It has definitely been shown that rough handling and manipulation of cancerous condition tend to loosen cancer cells, which metastasize to adjacent lymph nodes, bones and other organs. These facts emphasize the need of care and caution in the examination and treatment of suspected cases and those known to be malignant.

Research is enlightening all fields of medicine and surgery. It has advanced until it now assumes an independence and importance as a separate branch of medicine. It has its own methods, procedures, technique, and has fast become recognized as indispensible to the progress of medicine. Experiments with benzene and its compounds have artificially produced cancer, which has been passed on in mice and rats for thirty-seven generations. Dr. Lumden and his co-workers in London have produced a sheep serum which, injected into implanted mouse tumors, produce destruction of the tumor and absorption of the cell, cancer immunity following. In a control group with normal sheep serum the tumors were not affected. But he continues to deny a cure. Cancer has been conveyed to mice by means of the inoculation of the cell products without living cancer cells. The disease tends to appear in some strains while others are immune, showing that cancer runs in certain families and that a predisposition to it is hereditary. Attempts to graft human cancer upon animals have failed, but grafts from one animal to another of the same species are successful. The fowl sarcoma of Rous is the only cancer which has transplanted without the use of living cells. This has been transplanted by means of a filtered virus. Krecker states that we should look for the etiology of cancer in a lowered resistance of connective tissue to the penetration of epithelial cells. In addition to individual research several new hospitals have been endowed for the treatment of cancer. And in the meantime the Medical Society tries to protect the public from exploitation of unauthorized methods of treatment.

In making a diagnosis of cancer one cannot always wait for the development of the usual text book picture. Such a delay is dangerous and often fatal. Cure depends upon early diagnosis and treatment. Many a borderline case must receive treatment to prevent a later possible malignancy. Biopsy here is of great value, provided

the proper laboratory facilities are available. In the smaller hospitals such means are not always at hand and the operation is completed without a frozen tissue section in the operating room. Bloodgood says that the mortality of cancer will decrease when the physicians begin to make frozen tissue section at the time of operation. Tumors of the breast lend themselves readily to this type of examination. Biopsy is used wherever enough tissue can be obtained to insure a pathological report.

Hasley says that the X-ray is the most dependable method of diagnosis for cancer of the stomach. This type of cancer makes up one-third of the total yearly cancer mortality. One does not wait for loss of weight, anemia or a palpable tumor mass in the epigastrium. Early symptoms may be any gastric disturbance or maldigestion. Early surgery will prolong life and often cure. Rectal examination should be a routine in any complete examination, not for the rectum alone but also for the prostate gland. Direct inspection of the cervix is also a matter of routine. Weaver states that a gynecological examination should be made a routine procedure once a year in all women over thirty. A traumatized cervix is responsible for ninety-five per cent of cancer in this organ.

Radon implants have been one of the most worthy contributions to the treatment of cancer. Wherever radium formerly could be used, now radon in gold, platinum and glass seeds can be obtained and used in any community in this country. The perfection of the radio knife is another valuable contribution to the treatment of benign and malignant conditions. Small warts, moles and tumors can be removed with this knife. Many cases of advanced cancer can be dessicated in combination with radium and X-ray and will yield results unobtainable by any method used alone. The most valuable use of this knife is in the treatment of malignancy in the prostate and the bladder.

Surgery has decreased the mortality of early cancer of the rectum and in which the technique has become more nearly perfect. In advanced cases the permanent colostomy still offers some relief from pain. Cancer of the uterus, breast and stomach are best treated by early surgery, and radium and X-ray may be used in the first two, either alone or with surgery. Cancer of the tongue, lips, and buccal areas where early metastasis is the rule are treated by radical removal and dissection where necessary.

The high cost of radium makes it prohibitive to the vast majority of cases not within a cancer clinic. Because of this more cases are treated with small amounts of radium over a longer period of time. Most physicians prefer to use this method in treatment of cancer of the cervix. Some follow this with deep X-ray therapy. Many cases of skin cancer and superficial non-metastasizing types are preferably treated by radium, but the early metastasizing cancer may not respond to this therapy.

X-ray is used in both superficial and deep therapy. The treatment varies with the resistance and the strength of the patient. Cancer of the cervix is treated with fractional doses over separate points several times a week. In both radium and X-ray treatment most physicians prefer not to destroy the skin. In one European clinic, however, sufficient dosage is given in superficial cancers to cause an extensive slough of the skin.

There are some forms of tumors which yield more readily to treatment than others. It is not uncommon to see tumors melt away like magic before the Roentgen ray.

At the present time there is no standard of dosage for either X-ray or radium. The X-ray is measured in R-units and radium in milligram hours or radon in millicuries. Dosage is prescribed in these terms in the large clinics. Hardly any similar system exists in any two clinics. As long as this condition exists treatment remains in the experimental stage.

Prevention of cancer lies in the education of the public to the early signs and symptoms of cancer. This should also include periodic examination and early and adequate treatment by such methods as have already been mentioned in the summary above.

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Hollywood, The Convention City



Bring your bathing suit

In selecting a site for international statesmanship, powers of the world agreed on Geneva, principally because of the beauty of the Swiss city. It was believed at the time, and since has been proven, that exclusiveness and beauty are beneficial in the matters of governmental deliberation.

With the experience of world diplomats as a criterion, the Florida Medical Association should experience its greatest and most productive meeting at Hollywood in the Hollywood Beach Hotel. Florida's most magnificent resort structure will be turned over in its entirety to the members of the Medical Association for the annual convention.

Located on the broad Atlantic ocean, but eighteen miles away from the heart of Miami, the Hollywood Beach Hotel possesses all the attributes of the perfect convention hotel. More than forty organizations have scheduled conventions at the hostelry this year, concretely testifying to the attractions of "Florida's Finest."

The entire city of Hollywood, together with the hotel staff, are making plans for the entertainment of the many doctors who will attend the session. The community is firmly resolved to send the visitors home pleased and determined to again pay another visit to the coming convention city of the South.

Among the entertainment features scheduled for the Medical Association are dancing on the outdoor deck under tropical skies, beach sports, golf tournaments, shuffleboard, ping pong, card games and all the varied attractions that feature the hotel program during the regular winter season. Ladies' and men's solaria on the roof of the hotel are also expected to prove popular with those desiring health-giving sun rays.

The hotel has its own private bathing beach, with direct from room to beach elevator service, an innovation exclusive with the resort. Luncheon on the promenade is also a popular service.









Patio of Hollywood Beach Hotel

It is believed that an unprecedented number of wives, daughters and sweethearts of the members of the Medical Association will attend the Hollywood convention, due to the magnificent program offered and the perfect setting. The convention gives an opportunity for a seashore vacation for inland people that cannot be paralleled anywhere in the United States. Those desiring to come two or three days in advance of the session and stay a few days after the convention closes will be accommodated at the same special convention rates.

Featured attractions for the ladies include bridge games, sight-seeing, dancing, bathing, etc. A local committee on feminine entertainment will conduct this part of the program.

Ample conference rooms make it possible for the Florida Medical Association to hold all of its deliberations under one roof. Outdoor meetings in the patios and outdoor lounging decks will also be offered. The hotel is located in the center of a ten-acre tropical park, constantly cooled during the summer by ocean breezes.

Five hundred rooms with either ocean front or park exposure will be available for the convention. Coolness will be the keynote. Between sessions the ocean will constantly beckon its surf-bathing lure.

All in all, Hollywood and the Hollywood Beach Hotel promises the greatest of all Florida Medical Association conventions.



Boats from Ft. Lauderdale Guide Boat Association will be at the hotel door.

PROGRAM

of the

SIXTIETH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT HOLLYWOOD, FLORIDA

MAY 2nd, 3rd, and 4th, 1933

INFORMATION

Information desk will he located in the lobby of the headquarters hotel, The Hollywood Beach Hotel, with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are requested to register. Tickets for the hanquet, Wednesday evening, May 3rd, may be obtained at the registration desk.

HOTEL

Hollywood Beach Hotel—Convention headquarters.

RATES (European Plan)

Single$3.00 Double$5.00

MEALS (Minimum Rates)

Breakfast 35c. Luncheon..... 65c.
Dinner.....$1.00

ENTERTAINMENT

Golf. Annual tournament, Hollywood Country Club. Green fees, 75c.

Fishing trips. Guide boats from the Ft. Lauderdale Guide Boat Association will be at docks in front of hotel. Special rates from Sunday to end of convention.

Swimming and Surf Bathing. Bring your swimming suits.

Tuesday, May 2nd

8:30 p.m. Informal Smoker (stag). Recreation Rooms, south end of beach floor, Hollywood Beach Hotel.

8:30 p.m. Bridge Party.

Wednesday, May 3rd

9:00 p.m. Annual Banquet. Hollywood Beach Hotel. Tickets ($2.50) may be obtained at registration desk. Entertainment and dance intermittently.

PROGRAM FOR WOMEN

Tuesday, May 2nd

3:00 p.m. Cabana Party. Courtesy Broward County Medical Auxiliary.

8:30 p.m. Bridge Party.

Wednesday, May 3rd

12:30 p.m. Board Luncheon. (75c).

2:30 p.m. Ocean Trip. Large U.S.S. Unalga. Courtesy Broward County Medical Auxiliary.

9:00 p.m. Annual Banquet, Entertainment and Ball. Hollywood Beach Hotel.

Thursday, May 4th

9:30 a.m. Annual State Auxiliary Meeting.

12:30 p.m. Auxiliary Luncheon. (75c).

TECHNICAL EXHIBITS

Technical exhibits will he located in booths in the lobby of the Hollywood Beach Hotel.

The technical exhibits have a real scientific value and physicians who wish to keep abreast of the times and know the latest in drugs and medical appliances should spend some time with these exhibits. It will be surprising the amount of useful information that can be procured at these exhibits. Many have nothing for sale, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Hollywood meeting:

American Optical Co.
Gerber Products Division
Mead Johnson & Co.
National Drug Co.
Surgical Supply Co.

OFFICERS OF BROWARD COUNTY MEDICAL SOCIETY

H. J. PEAVY, *President*

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COMMITTEE ON EXHIBITS AND REGISTRATION

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Mrs. Arthur L. Walters, Vice-President....Miami Beach
Mrs. Ernest W. Veal, Sec'y-Treas. So. Jacksonville
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Mrs. L. F. Robinson
Mrs. F. S. Skiff
Mrs. R. H. Stovall

FIRST GENERAL SESSION

Tuesday, May 2nd, 1:30 P. M.

Call to order, A. B. Connor, Chairman of Convention Committee.
Invocation, The Reverend John G. King, pastor, Presbyterian Church, Ft. Lauderdale.
Introduction of Georgia Delegates.
Announcements.

President Holden in the Chair.

Report of officers:
- Secretary-Treasurer-Editor, Shaler Richardson, and Business Manager, Stewart Thompson.
- Executive Committee, O. O. Feaster.
- Committee on Legislation and Public Policy, W. M. Rowlett, Tampa.
- Hospital and Medical Education Committee, Walter A. Weed.
- Council, Ralph N. Greene.
- Committee on Necrology, Henry C. Dozier.
- Public Relations Committee, Thomas E. Buckman.
- Special Committee on Post-Graduate Work, T. Z. Cason.
- Other Special Committees.

SCIENTIFIC ASSEMBLY

Tuesday, May 2nd, 3:00 P. M.

Committee on Scientific Work: L. M. Anderson, Lake City; Leland F. Carlton, Tampa; Edward Jelks, Jacksonville.

Attention is called to the following By-Laws:

"All papers read before the Society shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orators, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, nor more than once on any one subject."

Drs. Cunningham and Shaw have offered their projecting lantern and daylight screen. Essayists desiring to present lantern slides are asked to communicate before the meeting with Dr. A. B. Connor, Ft. Lauderdale.

1. "Poisonous Effect of the Nuts of the Tung Oil Tree if Eaten by Man," Henry E. Palmer, Tallahassee.

 Introduction of tung oil tree into America. Symptoms caused by ingestion of fruit from tree. Probable action on intestinal viscera. Treatment.

 Discussion: T. M. Rivers, Kissimmee; George C. Tillman, Gainesville.

2. "Treatment of Hemophilia with Ovarian Extract," Joseph S. Spoto, Tampa.

 Definition of hemophilia. Review of recent literature. Report of two cases. Treatment and results. Discussion of treatment. Summary and conclusions.

 Discussion: Herbert R. Mills, Tampa; Robert G. Nelson, Tampa.

3. "Lymphopathia Venerea," Alan Brown, Jacksonville.

 This condition has been termed strumous and climatic buboe, Nicolas-Favre's disease, lymphogranulomatosis inguinalis, etc. It is endemic in Florida, seldom recognized, occurs in males and females, predominantly in negroes. Etiology, pathology, diagnosis and treatment are considered.

 Discussion: J. L. Kirby-Smith, Jacksonville; E. D. French, Miami.

FIRST MEETING OF HOUSE OF DELEGATES

Tuesday, May 2nd, 5:00 P. M.

President Holden in the Chair.
Roll Call and Seating of Delegates.
Adoption of Minutes as published in May, 1932, Journal.
Consideration of Revised Constitution and By-Laws.
Election of one delegate and one alternate to A. M. A. meeting (2-year term).
Selection of meeting place of Association for 1934.
Reading of Resolutions.
Unfinished Business.
New Business.
Announcements.
Adjournment.

SCIENTIFIC ASSEMBLY

Wednesday, May 3rd, 9:00 A. M.

4. "Appendicitis with Its Increasing Mortality," Herbert E. White, St. Augustine.

 Factors accountable for ever increasing mortality rate from appendicitis stressing responsibility of doctor, patient, and patient's family. Mortality rate of Florida has doubled in past ten years. An appeal to profession to disseminate information to further educate the public to reduce this rate.

 Discussion: John E. Boyd, Jacksonville; John W. Snyder, Miami.

5. "A Review of Some Urinary Anomalies and Pathologic Conditions Producing Symptoms of Especial Interest to the General Practitioner," (lantern slides), Roy J. Holmes and M. M. Coplan, Miami.

 Enormous hydro-pyonephrosis with nausea and vomiting and flatulency leading to a diagnosis of colitis. Ureterocele with persistently negative urine, but producing marked frequency of urination leading to a diagnosis of "nervous bladder." Severe nephroptosis with anemia and asthenia, diagnosed as probable cancer of the cecum. Many other interesting cases which are reported because of the fact that none had specific urinary symptoms, but all were producing symptoms which naturally lead to a consideration of pathology elsewhere than along the urinary tract.

 Discussion: J. C. Vinson, Tampa; E. T. Sellers, Jacksonville.

6. "Carcinoma of the Colon," Geo. M. Dawson, West Palm Beach.

 A recital of the early symptoms of carcinoma of the colon calling attention to their resemblance to symptoms of minor intestinal disorders. Variation in the symptoms of tumors in the right and left halves of the large intestine explained on the basis of the physiology of the bowel and pathology of the tumors. Three common mistakes in the early diagnosis illustrated by case records. Summary.

 Discussion: J. W. Snyder, Miami; Leigh F. Robinson, Ft. Lauderdale.

SECOND GENERAL SESSION

Wednesday, May 3rd, 10:30 A. M.

Vice-President Halton in the Chair.

Address of President, Gerry R. Holden.

Address (by invitation), "Brain Tumors, Their Diagnosis and Treatment," Walter E. Dandy, Baltimore, Md.

Address (by invitation), Sam R. Marks, of Marks, Marks, Holt, Gray & Yates, Legal Advisors of Florida Medical Association.

SCIENTIFIC ASSEMBLY

Wednesday, May 3rd, 2:00 P. M.

7. "Cerebral Injuries of the Newly Born," James H. Fellows, Pensacola.

 Injuries from obstetric as well as pediatric point of view. Charts will illustrate mechanism of injuries.

 Discussion: W. W. McKibben, Miami; Luther Holloway, Jacksonville.

8. "Placenta Previa," Homer L. Pearson, Miami.

 Diagnosis, treatment, and results of some eighteen cases handled at the Jackson Memorial Hospital. Brief review of current literature.

 Discussion: C. J. Collins, Orlando; Ferdinand Richards, Jacksonville.

9. "Granuloma Inguinale," R. B. Harkness, Lake City.

 An infectious ulcerative condition most frequently found on the genitals and adjacent structures. Diagnosis is suggested by location, chronicity, and resistance to non-specific treatment. Confirmed by microscopic findings (Donovan Bodies), and by rapid healing under specific treatment. Intravenous administration of antimony. Report of case of eighteen years' standing.

 Discussion: E. T. Sellers, Jacksonville; E. D. French, Miami.

10. "Observation of Five Hundred Fractures," Joseph Halton, Sarasota.

 Five hundred fractures extending from 1926 to 1933, with X-ray films. Report from the standpoint of early treatment, X-ray, end results, and demonstration on applying a home-made banjo splint.

 Discussion: Leland F. Carlton, Tampa; J. C. Dickinson, Tampa.

11. "Fractures at the Ankle and Wrist Joints," (lantern slides), W. M. Shaw, Jacksonville.

 Anatomy, normal movements, mechanism of fracture. Types of fracture, Epiphyseal injury with end results. A method to determine the prognosis of ankle and wrist fractures by X-ray examination following reduction. Lantern slides.

 Discussion: Edward Jelks, Jacksonville; O. O. Feaster, St. Petersburg.

12. "Fractures of the Cervical Spine Below the Atlas and Axis with Report of Two Cases," Geo. E. W. Hardy, Tampa.

 (1) Etiology. (2) Diagnosis; roentgenologic examination; neurologic examination. (3) Treatment: Cases without evidence of cord injury; cases with evidence of cord injury; indications for and against laminectomy; technique of laminectomy; post-operative care. (4) Return of function. (5) Report of Cases. (6) Demonstration of pneumatic traction.

 Discussion: H. Mason Smith, Tampa; F. L. Fort, Jacksonville.

SECOND MEETING OF HOUSE OF DELEGATES

Wednesday, May 3rd, 5:00 P. M.

Unfinished Business.

SCIENTIFIC ASSEMBLY

Thursday, May 4th, 9:00 A. M.

13. "Use of Unsweetened Evaporated Milk in Infant Feeding. A Study of 300 Cases," (lantern slides), Warren Quillian, Coral Gables.

 (1) Observations on a series of normal infants fed on evaporated milk. Clinical cases observed periodically at the City Welfare Clinic and followed up by the city health nurse. Cases observed in private practice. (2) A brief review of the experiences of pediatricians in various parts of the country as to the value and digestibility of evaporated milk in infant feeding. (3) Lantern slides. Tables giving a summary of our experiences with evaporated milk. (4) Conclusions.

 Discussion: George L. Cook, Tampa; W. W. McKibben, Miami.

14. "Unilateral Exophthalmos with Case Report," (lantern slides), Joseph W. Taylor, Tampa.

 A review of the various cases of exophthalmos. Kroenlein's operation. Recovery. Lantern slides.

 Discussion: Shaler Richardson, Jacksonville; W. Y. Sayad, West Palm Beach.

15. "Heart Disease of the Rheumatic Type," (lantern slides), C. F. Roche, Miami Beach and T. Duckett Jones, Boston, Mass.

 Presentation of a transportation experiment covering a period of three years concerning children selected from the cardiac groups of the House of the Good Samaritan and the Massachusetts General Hospital. Lantern slides.

16. "Hypothyroidism in Adolescent Girls with Particular Reference to Social Delinquency," T. Z. Cason, Jacksonville.

 A presentation of a number of cases of hypothyroidism in young girls, who are social (not moral) delinquents. These cases are largely incorrigibles, but when they reach a proper metabolic balance have adjusted themselves to a normal social invironment. Many cases unrecognized who continue to be social delinquents. If studied and properly handled, they could easily adjust themselves.

 Discussion: M. Jay Flipse, Miami; W. C. Blake, Tampa.

17. "Some Problems of Medicine," Henry C. Dozier, Ocala.

 Problems enumerated. Discussion of cost of medical care, including reference to the report of Committee on Cost of Medical Care. Health insurance. Recommendations for a program by Florida Medical Association to work out solutions to problems.

 Discussion: G. H. Edwards, Orlando; A. L. Mills, St. Petersburg.

18. "A State Health Department's Service to the Medical Profession," Henry Hanson, Jacksonville.

 (1) Laboratory; routine; research. (2) Library: reference material. (3) Investigation of diseases of unproven etiology. (4) Application of results.

 Discussion: Leland F. Carlton, Tampa; M. Jay Flipse, Miami.

THIRD GENERAL SESSION

Thursday, May 4th, 12 Noon.

President Holden in the Chair.
Unfinished Business.
New Business.
Election of President.
Newly elected President escorted to the Chair.
Election of President-elect.
Election of First Vice-President.
Election of Second Vice-President.
Election of Third Vice-President.
Election of Secretary-Treasurer.
Presentation of Past-President's Button.
Adjournment.

PROGRAM OF THE FOURTEENTH ANNUAL MEETING OF THE FLORIDA RAILWAY SURGEONS' ASSOCIATION

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HOLLYWOOD BEACH HOTEL

May 1st, 12:00 Noon

Round Table Luncheon, George C. Tillman, Gainesville, President, presiding. ($1.00).

OPENING SESSION

May 1st, 1:30 P. M.

Call to Order, Harrison A. Walker, Miami Beach, Chairman Local Arrangements Committee.
Invocation, The Reverend Thomas H. Sprague.
Address of Welcome on Behalf of City of Hollywood, Honorable James A. Lewis, Mayor.
Address of Welcome on Behalf of Broward County Medical Society, A. B. Connor, Ft. Lauderdale.
Response to Address of Welcome, Vernon A. Lockwood, St. Augustine.
President's Address, George C. Tillman, Gainesville.

SCIENTIFIC PROGRAM

May 1st, 3:00 P. M.

Address (by invitation), "Diverticulitis and Cancer of the Colon," Frank K. Boland, Professor of Surgery, Emory University, Atlanta, Ga.

1. "Extensive Ringworm Infection, a Disabling Factor in Warm Climates," (lantern slides), J. Lee Kirby-Smith, Jacksonville.
 Discussion: E. W. Potthoff, Titusville;
 A. E. Drexel, Palatka.
2. "Arthritis in Industry," T. M. Rivers, Kissimmee.
 Discussion: H. E. Palmer, Tallahassee;
 H. Gates, Bradenton.
3. "Interesting Phases in The Practice of Proctology," Jack Halton, Sarasota.
 Discussion: Herman Watson, Lakeland;
 Leigh F. Robinson, Ft. Lauderdale.
4. "Varicose Veins and Varicose Ulcers of the Lower Extremities," A. E. Drexel, Palatka.
 Discussion: J. Ralston Wells, Daytona Beach;
 H. D. Van Schaick, Jacksonville.
5. "Fractures of the Cervical Vertebrae," John S. McEwan, Orlando.
 Discussion: George E. W. Hardy, Tampa;
 I. M. Hay, Melbourne.

Reports of Interesting Cases.

6. "An Unusual Stab Wound of Head and Nasal Accessories," Henry E. Palmer, Tallahassee.
7. "Sloughing of Gluetus Maximus Muscle in Toto, Following Trauma to Buttock," L. W. Martin, Sebring.

BUSINESS SESSION

May 1st, 5:00 P. M.

Report of Committees.
Induction of President-elect into office.
Election of Officers.

PROGRAM OF THE SPRING MEETING OF THE FLORIDA RADIOLOGICAL SOCIETY

OFFICERS

President, O. O. Feaster.....St. Petersburg
Vice-President, Frederick K. Herpel...West Palm Beach
Secretary-Treasurer, W. M. Shaw.....Jacksonville

HOLLYWOOD BEACH HOTEL

Monday, May 1st, 2:00 P. M.

Scientific Program. Case Reports illustrated by films and lantern slides. Round table discussion.

Monday, May 1st, 7:00 P. M.

Dinner. Hollywood Beach Hotel.

Tuesday, May 2nd, 10:00 A. M.

Round table discussions followed by business meeting. Election of officers. Selection of meeting place of next meeting.



Ocean trip on U.S.S. Unalga



DR. WALTER E. DANDY, OUR HONOR GUEST

Doctor Walter E. Dandy is professor of neurological surgery, Johns Hopkins Hospital. Doctor Dandy originated the technique of air injection of brain ventricles for the identification and localization of space encroaching intracranial lesions. The procedure has now come to be universally recognized. Among many noteworthy accomplishments by Doctor Dandy has been the demonstration, by animal experimentation, that the pituitary is not essential for preservation of life. Outstanding accomplishments have been brain lobe resections, complete resection of a brain hemisphere above the basal neuclei for prolongation of human life in widespread and otherwise inoperable brain tumor; the resection of the sensory branch of the trifacial through an occipital approach of the branch as it emerges from beneath the pons; the operation being pain relieving and not accompanied by the usual residuals of anesthesia and keratitis as is at times encountered in the usual operative procedure of a temporal approach. The operation of intracranial division of the eighth nerve for cure of Meniere's disease, establishment of an artificial foramen of Monro for cure of obstructive hydrocephalus, and cervical sympathectomy for cure of migraine, are other noteworthy accomplishments of Doctor Dandy. Rarely may one peruse literature devoted to neuro-surgical problems without Doctor Dandy being freely quoted therein.

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone: 5-6186

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THE HOLLYWOOD MEETING

The next annual meeting of the Florida Medical Association will be held at Hollywood Beach, Florida, May 2, 3, and 4.

The local Committee on Arrangements has been very active during the year for the entertainment of our members and promises to make this a convention which none who attends will ever forget.

Through the courtesy and public spirit of the management of the Hollywood Beach Hotel, this magnificent hostelry will be turned over to our use with no thought of profit except the good will of the physicians of Florida and their families.

The assembly hall for the scientific sessions is on the ocean side, cool and delightful, with arrangements for darkening for lantern or motion picture illustrations. The entertainment program is replete with novelties and interesting features which the facilities of this world famous hotel makes possible.

POST-GRADUATE COURSES

The special committee, which is making arrangements for the post-graduate course to be given in conjunction with the Extension Department of the University of Florida during the week of June 19th to 24th, reports that plans are progressing satisfactorily.

Since the last announcement in the Journal, the following men have agreed to give the courses specified: Dr. J. R. McCord, Professor of Obstetrics at Emory University, Atlanta, Obstetrics; Dr. C. G. Coakley, Professor of Otolaryngology at Post-Graduate Hospital, New York City, Ear, Nose, and Throat; Dr. J. A. Kolmar, Professor of Medicine at Temple University, Philadelphia, General Medicine, and Dr. W. A. Mulherin, Professor of Pediatrics, University of Georgia, Augusta, Pediatrics. As previously announced, Dr. Wayne Babcock, also of Temple University, will give the course in General Surgery. As all subjects will be taken up from the standpoint of the general practitioner, the course should prove most valuable.

Publicity regarding the course is being sent out by the Extension Department and members of the committee, Dr. T. Z. Cason, chairman; Dr. G. C. Tillman, and Dr. T. H. Bates, will be glad to answer any questions.

TECHNICAL EXHIBITS

The management of the Technical Exhibits at the Hollywood convention will again be in the hands of the business office of the state Association. For four consecutive years the exhibits have been handled by the Association and this arrangement has apparently worked out to the best interests of all concerned. Both exhibitors and the different entertaining societies have expressed themselves well pleased.

Exhibit spaces will be available in the lobby of the Hollywood Beach Hotel. Our members are urged to visit the booth of every exhibitor. The doctor who keeps himself abreast of the times will find the exhibits both interesting and instructive.

CORRESPONDENCE

TESTIMONIALS FOR YEAST

To the Editor:

It has been brought to the attention of the Vienna Medical Faculty that medical testimonials favoring one of the yeast preparations placed on the market by the Fleischmann Yeast Company in New York have been placed at the disposal of this company by certain members of the medical faculty in Vienna, and that these testimonials are spread and misused for advertising purposes in American illustrated and other magazines in quack-fashion. Even though the testifiers in question cannot personally be responsible for this misuse, since they have no power of might against the unfair methods employed by the yeast firm, nevertheless the Vienna Medical Faculty instituted an extensive inquiry into this matter in June, 1932. The members at fault were officially sharply reproved by the dean, and all members of the faculty were forbidden to give any testimonials intended for advertising purposes in the future.

All of the 328 members of the medical faculty were officially advised of these proceedings. Incidentally, not a single member of the Board of Professors (heads of departments) of the medical faculty is involved in this affair. Seven privat-dozents not included on the board, and not one of whom either has the official position of teacher or is in charge of a department, are concerned here. (Privatdozents, according to the statutes of the universities of Austria, are not appointed by the state but merely permitted by the state to teach.)

In consideration of the fact that through the impropriety of these advertisements the reputation and esteem of the Vienna Medical School could be seriously affected among the medical men and people of America, we ask the American Medical Association to take cognizance of the foregoing explanation of the situation and to spread this information among its members through its publishing organ, and if possible also publicly.

Prof. Dr. Ernst Pick,
Dean of the Medical Faculty and Director of the Pharmacologic Department.

Prof. Dr. Roland Grassberger,
Former Dean of the Medical Faculty and Director of the Hygienic Department.

Vienna, Austria.

Reprinted from Jour. A. M. A. Jan. 7, 1933.

RADIO BROADCASTS, 1932-1933

The following broadcasts were arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

MAN'S PLACE IN NATURE*

THOMAS E. BUCKMAN, M.D.,
Jacksonville.

During recent years, it has become more and more the fashion to present educational addresses over the radio. We have heard many excellent, informative lectures by prominent speakers covering a wide variety of subjects:—political economy, psychology, history, literature, music, and even physics, chemistry and astronomy. In medicine, much sound advice has been given concerning public health and private hygiene. Yet very little has been said concerning the part that Medicine, in its broadest sense, has played in the development of modern civilization. In view of this, the Florida Medical Association is sponsoring a series of broadcasts to be given bi-weekly over this station. The first part of the series will deal with the historic significance of medicine—not the history of medicine itself, for that would be largely technical, but rather the influence of medicine on the course which our civilization has taken. The second part of the series will deal with the scientific basis of modern medicine, showing that the progress which medicine has made has depended on the progress made in physics, chemistry and biology on the one hand, and, on the other, on the introduction into medicine itself of the methods common to all the sciences.

In the past, historians evidently have not felt that the influence of medicine in shaping the course of events is very important. Every school boy knows the names of the great conquerors and explorers, and he generally knows something of the political, economic, religious and cultural factors of history, but even the educated adult is largely ignorant of the names of the men and women who have made it at least *possible* to banish famine from the earth and to free mankind from his greatest plagues. Moreover, although most people will concede the importance of health as a personal matter, few realize the significance of medicine in the development of the present social order.

President Lowell of Harvard University once said: "It is hardly an exaggeration to summarize the history of 400 years by saying that the leading idea of a conquering nation in relation to the conquered was in 1600 to change their religion; in 1700 to change their law; in 1800 to change their trade, and in 1900 to change their drainage. May we not say that on the prow of the conquering ship in these 400 years first stood the priest, then the lawyer, then the merchant, and finally the physician."

I think this is somewhat of an understatement with respect to the influence of medicine. Those great changes, which are generally spoken of as the Industrial Revolution:—the growth of rapid transportation, the development of factories, the rise of large cities, and the scientific exploitation of the soil and mineral wealth of the world—had their beginning in the eighteenth century and have been dependent on the progress of hygiene, sanitation and preventive medicine. As Dr. Haggard, professor of applied physiology in Yale University, in his recent book, "The Lame, the Halt and the Blind," points out: if foods were not adequately protected, if sewage was not properly disposed of, if vaccination against smallpox and other diseases ceased to be practiced, if quarantine against the epidemic diseases were removed, then the great plagues would return to decimate the population, aggravated by these very means of rapid communication on which our industrial civilization depends. As he further points out: if, for example, our knowledge of electrical engineering were obliterated our civilization would be set back, say fifty years, but if our knowledge of preventive medicine were obliterated, we should have to return to the conditions of the early middle ages—small, isolated communities and slow transportation.

If, then, medicine has been of such importance in the evolution of society, it would seem that its influence would be a matter of the greatest concern. Why, then, has it received so little recognition in recorded history? I believe that the answer is fear—the fear that we may be proved to be "of the earth, earthy," the fear that if the great adventures of mankind can be shown to be dependent somehow on such homely matters as sanitation and food supply, then man will suffer an irretrievable loss in dignity. It flatters us to think of all history only as political history, as a

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, October 16, 1932.

series of dramatic events, the free acts of great individuals largely independent of underlying biologic and economic forces. Until the last century, this was the commonly accepted interpretation of history. Since the middle of the 19th century, however, the economic forces of history have acquired wide recognition and now, in the minds of some, completely overshadow the political forces. It is time that the biological forces, among which are medicine and sanitation, receive adequate treatment. The failure to do so in the past has, I believe, been the cause of much mischief. Let me tell you why I think so.

In the thirteenth century, man, in his own opinion, held the highest place in nature that he had ever held. He thought that he was lord of the earth and that his earth was the center of the universe. Yet in reality his position, as measured by his ability to control his environment, was exceedingly humble. He was not protected against cold and storms, and could use to his advantage relatively few of the forces about him. He had no defense against famine, and in a very practical sense he was helpless against infectious diseases. The onslaughts of the very lowest forms of life, the bacteria and filterable viruses, annually killed millions of human beings. Indeed, so great was the mortality from such diseases that in spite of stupendous efforts at reproduction, the population of Europe had remained almost constant for centuries. In spite of man's notion that he occupied a special and exalted place in nature, his actual position had hardly advanced beyond the point which it had reached at the close of the last ice age.

During the Renaissance, the substitution of observation and experiment for traditional views made the notion of the earth as the center of the universe untenable. If this lowered man's opinion of his place in nature, it marked the beginning of his long, heroic, and successful struggle to gain dominion over his environment. During the nineteenth century the extension of the scientific method to the domain of living things again questioned the special significance of man in the universe but the same methods also gave him the means of banishing famine, poverty and the great pestilences. In our own times, the astronomers tell us that our earth is a middle-aged planet, revolving around a declining sun, placed near the edge of the galactic system of billions of stars. It is even suggested that life itself is a mere incident of nature, a sort of disease that creeps upon matter in its old age. But what difference does it make? If man has given up his quit-claim deed to a metaphysical world, he has secured a warranty deed to the material world. He holds in actuality the most exalted place in nature of any time in history. Almost in direct proportion to the extent that man has admitted his earthiness he has gained dominion over his earth. After all, Poverty, Famine, Disease and War; these are the burdens that prevent man from attaining his highest destiny. As in the past with respect to economic factors, so at present with respect to biological factors, it is ignorance of their significance in history that permits us complacently to ignore them. And, it is ignorance of the past successes and future possibilities of the medical sciences, among others, which makes us fear that their recognition and advancement might somehow lower our dignity.

It is generally known that over twenty million men were killed in the Great War, but it is not generally known that smallpox, single handed, killed *not twenty* but *sixty* million people in the eighteenth century alone. The discoveries of Columbus and of the explorers who followed him in the sixteenth and seventeenth centuries are well known, but it is not well known that while these discoveries were being made bubonic plague killed *a quarter* of the population of Europe. We take it almost for granted that our children will live to reach manhood. We are not satisfied with mere survival. Rather, our interest lies in making them strong, beautiful and attractive. Yet two hundred years ago from one-half to three-fourths of all children born died before they reached two years of age, and of those who survived many were crippled and most were disfigured.

While it may be argued that today many are still in danger of starvation, at least we no longer strike coins to commemorate famine from "natural causes." Even if poverty is still with us, it is not because it is physically necessary, but because of our failure properly to utilize the knowledge that makes its abolition possible. If it be argued that modern war destroys more men than previous wars, it must be remembered that it causes fewer epidemics. Out of it have come some blessings. Napoleon ought to be remembered for immortalizing Jenner through the introduction of vaccination into his armies. Balaklava and Scutari ought to be remembered for sister Maria Theresa and Florence Nightingale,

respectively; their heroic and successful efforts laid the foundations of modern hospitals and modern nursing. Solferino ought to be remembered for Henry Dunant, the founder of the International Red Cross. Sister Maria Theresa, Nightingale, Dunant; these surely were the permanently great figures of these momentous struggles. They assuaged the brutalities of war and gave to us our most humane and effective methods for meeting the disasters of peace.

It is sometimes said that the softening influence of medical science, a better food supply and a better distribution of wealth are causing a deterioration of the morality, or at least of the character of the race. This argument is meaningless since no one has devised a method for determining the morality of any particular period of history. However, as regards medicine, this much, by way of illustration, can be indicated, at least as far as the West is concerned:—that the plague no longer drives parents to desert their children as it did in Mediaeval Italy; that it is no longer necessary for courtiers to use wigs and court plaster to cover up the ravages of syphilis; that our insane are no longer subjected to the tortures meted to hardened criminals. Should these facts and many more like them be construed as evidence of declining morality or character, then I fear we shall simply have to make the most of it.

If I have intimated that I believe we live in the best of worlds that has yet come to light, I do not mean to imply that I think it is the best of all *possible* worlds. If poverty and famine have not been abolished, if disease still stalks among us, and if war is still awful to contemplate, the responsibility does not rest with science, least of all with the medical sciences. As I have indicated, I believe the fault lies in ignorance fostered by fear and superstition. For the cure of this ignorance we must depend, as Huxley so eloquently pleaded "on veracity of thought and action and the resolute facing the world as it is when the garment of make believe . . . is stripped off."

MEDICINE AND SUPERSTITION*

THOMAS E. BUCKMAN, M.D.,
Jacksonville.

The last speaker in this series of broadcasts, sponsored by the Florida Medical Association, concluded his address by the statement that "for the cure of ignorance we must depend, as Huxley pleaded 'on veracity of thought and action and the resolute facing the world as it is when the garment of make believe . . . is stripped off' ". If this be true, it would seem appropriate to inquire into the causes which have made mankind accept the make believe in the hope that, knowing the causes, the make-believe might be more readily discarded.

Psychologists tell us that in human deportment, association plays a more important role than reason. As Professor James once said, most adults are merely "walking bundles of habits," reacting to stimuli according to custom and association. Let me explain the meaning of this more precisely by describing an experiment performed to determine whether a newborn infant was deaf. The baby was placed in a quiet room. Then a telephone bell was sounded. The baby made no characteristic response. Then, at the same time that the bell was sounded, the point of a needle was gently touched to the sole of one of his feet. The foot was withdrawn. Then the bell was sounded and the foot touched with the needle simultaneously, several times. Finally, the bell was sounded but the stimulus of the needle was omitted. Nevertheless, the baby withdrew the foot precisely as though it had been touched with the point of the needle. Now, there is no logical connection between the sound of the bell and the withdrawal of the foot but there is, in this case, a psychological connection. The baby learned to respond to the bell in the same manner in which he had originally and naturally responded to the touch of a needle. This learned, or psychological, response is spoken of as an association or conditioned reflex. The capacity to develop association response is one of the distinguishing features of animals with a central nervous system and forms the basis of all learning. Without this ability, we should be wholly at the mercy of our surroundings. We should never be able to put our experiences together.

Let me illustrate further what I mean. I said that a telephone bell was used in the tests on the baby. In adults this bell evokes a different kind of response. When it rings, we answer the telephone. Again, there is no logical connection between a voice over the telephone and the sound of the bell. We have learned through experience—repeated frequently enough to give us confidence and repeated recently enough to keep us from forgetting—to associate the bell with the voice. The

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, November 6, 1932.

association is not a certainty; sometimes the bell rings and the voice is not heard. The usefulness of the association consists in the fact that generally, if not quite always, we may expect to hear a voice after we hear the bell. But now suppose that we pick up the telephone even though no bell rings and hear the voice of someone who wishes to speak to us as frequently as we do when the bell rings. In this case, association has lost most of its value. We have learned, however, that when the telephone is silent no one is calling us. This, too, is a matter of association. We have learned to associate the absence of a characteristic sound with absence of some one calling. It works most of the time, but not invariably. Briefly, then, it may be said that useful knowledge is acquired by observing two very simple rules: on the one hand a particular event generally follows some special act; on the other hand, the particular event generally does not occur in the absence of the special act. In human beings, the process is enormously aided and complicated by articulate speech, without which each generation would have to begin at the beginning, but the introduction of this element does not fundamentally alter the rules of association.

Now you may ask: What has all this to do with medicine and superstition? My answer is that the failure to observe the simple rules of association, or induction, as the logicians call it, is at the basis of all superstition. But rather than treat the subject analytically I shall try to make it more attractive by citing concrete illustrations in which you will be able to see the results of fallacies in reasoning. But before I introduce medical illustrations, let me give a general example.

We often see an advertisement which reads somewhat as follows: "The President of the General Saws and Files Company always wears Red Moon Suspenders." Perhaps there is a picture of a prosperous-looking executive examining a pair of red suspenders. If the advertisement is repeated with sufficient frequency, the aroma of something pleasant—success—begins to become associated with Red Moon suspenders, and we are likely to ask for Red Moon suspenders the next time we have occasion to purchase this commodity. Having once purchased such suspenders and finding them dependable, we are likely to purchase the same kind thereafter, never taking the trouble to determine whether equally good or better suspenders might be obtained for the same or less cost. It is, as though, having found that when we answered the telephone bell the voice of some one wishing to speak to us was generally on the wire, we had ignored the possibility that we might hear the same voice even when the bell did not ring. We have, in short, succumbed to a superstition concerning the *special* merits of Red Moon suspenders. The ability of an individual in one field does not guarantee his qualification as expert in another field.

But you will say, "Surely we cannot be expected to test out for ourselves every commodity that is offered. Not only do we not have the instruments for doing that; we simply do not have the time." Quite true. Let us consider a case in point. When we see on a package of food stuff the statement, "Accepted by the Committee on Foods of the American Medical Association," we feel reasonably safe in eating that article of food. This is a most important matter. If we had to have every bit of food that we eat analyzed we might not die of poisoning but, by the same token, we should probably die of starvation.

Probably most people would accept the article approved by the medical bureau for the same reason they would accept the suspenders. In each case, there is an association of the commodity with something which people have learned to respect; in the one case, the prosperous executive; in the other case, the physician. Wherein, then, lies the difference? The endorsement of the executive is in the nature of a testimonial. The approval of the article of food is the result of scientific inquiry.

But enough of reasoning in the void. A few specific illustrations from history will prove my point.

One of the most curious forms of faith healing that persisted until the beginning of the industrial revolution was the attempted cure of diseased glands of the neck by the laying on of hands. The custom is said to have originated in England in the time of Edward the Confessor. As the story goes, a young woman, suffering from a swollen gland of the neck, was advised in a dream to have the part affected washed by the king. After the king had rubbed the swollen mass, the abscess discharged and the patient rapidly recovered. The story spread, and the notion became established that the king's touch would cure *any* swelling of the glands of the neck. The ability to cure swollen glands of the neck by royal touch became to be looked upon as part of the divine right of

kings and developed into an elaborate ceremony. It has been estimated that over 90,000 invalids sought relief at the hands of Charles II alone. The custom persisted until the beginning of the eighteenth century. The popularity of the king's touch is entirely analogous to the popularity of Red Moon suspenders. The superstition was accepted not only by the ignorant but also by many of the most prominent intellectuals of the time. Sir Thomas Browne believed in it. Samuel Johnson at the age of four was one of the last of the prominent men to be "touched," but Boswell testifies that he nevertheless suffered from the trouble all his life. In spite of the testimony, both explicit and implied, of so many great men, it is said that more people died of scrofula during the reign of Charles II than during any other period in English history.

The alleged cure of scrofula by the laying on of hands is an example of a superstition involving the association of personality and an institution. Towards the close of the eighteenth century, the experimental work on electricity began to attract the attention of the learned world. Electricity was a new and mysterious force. As that other mystery, the divine right of kings, began to be shattered this new mystery came into its own as the basis of a new superstition. Towards the close of the eighteenth century, James Graham, a native of Edinburgh, while traveling in America happened to hear of Franklin's discoveries in electricity. Graham's interest in electricity, unlike Franklin's, was not scientific. But he apprehended correctly that a new world would be built in which great machines would take the place of great persons. Perhaps the greatest of these machines would be the electric dynamo. He also understood that the new force could be made the basis of superstition.

Returning to Europe, James Graham established in London his Templum Aesculapic Sacrum. "In this tremendous edifice," as he said, "are confined or singly dispensed the irresistable and salubrious influences of electricity, or the elementary fire, air, and magnetism; three of the greatest of those agents or universal principles which, pervading all created beings and substances that we are acquainted with, connect, animate and keep together all nature." His principal instrument was his so-called Celestial Bed supported by forty pillars of glass and connected with various pieces of electrical and magnetic apparatus. Commenting on this device Professor Robinson in his book, "The Story of Medicine," says: "If the young lay in this bed, they would retain their good looks; if the old experienced its effects, they would be rejuvenated. The price for a night in this Medico-Magnetico-Musico-Electrical bed was 100 pounds, and the fee was paid by human beings who were entitled to engrave a crest on their tombstones." At the beginning of the Industrial Revolution, man had become not less credulous, only less pious than he had been in the middle ages! In our own day, a century and a half later, he has apparently not changed. But because we have always been foolish in the past is no reason for continuing so indefinitely.

The story of the King's Touch and the story of the Celestial Bed of Graham are illustrations of types of superstitions based upon psychological rather than logical association. Another type of superstition is that which depends on what has been called "after-this-therefore-on-account-of-this" reasoning. In the case of the telephone illustration, which I have mentioned, we have learned to associate the sound of the bell with the notion that some one wishes to speak to us. At the same time, we have also learned that when the bell is not ringing there is no one calling us. While we have learned this in special cases, we have evidently not learned it in principle. Let me now describe a single story from the history of medicine that will illustrate what I mean.

During the latter part of the eighteenth century, a certain Doctor Elisha Perkins of Connecticut, impressed as was James Graham with the remarkable possibilities of electricity, announced that he had invented a device which would cure the most obstinate cases of disease which had failed to respond to medical art. His device consisted of two metal rods made of brass and iron, known as Tractors. It was customary to draw the instruments from the pained part to the extremities. By such maneuvers it was supposed that disease could be drawn out of the body. In spite of the fact that Perkins was expelled for his fraud from the Connecticut Medical Society, many of the great of the time bought these tractors and gave testimonials as to their worth. But it was too good to be true. Finally, two physicians in England made tractors out of wood, painted to look like the Perkins Tractors. The results obtained with the wooden tractors were as good as those obtained with the metal tractors. Then, of course, the superstition of a special virtue residing in the metallic rods became unten-

able. Meanwhile, the son of Elisha Perkins had sold so many tractors in England that he could return to America with a profit of fifty thousand dollars.

What made the tractors apparently so successful? Just this. The majority of cases of illness get well *without* any treatment, or *with* any harmless treatment. "After-this-therefore-on-account-of-this" is a psychological but not a logical argument. Why do so many great persons give testimonials about things concerning which they have no scientific knowledge? I do not know, but it is evident that success in one field is not necessarily a valid ground for expressing trustworthy opinion concerning matters in another field. As Mr. Bertrand Russell says in his "Sceptical Essays": "It is undesirable to believe a proposition when there is no ground whatever for supposing it true"—"When experts are agreed, the opposite opinion cannot be held to be certain. When they are not agreed, no opinion can be regarded as certain by a non-expert. When all experts hold that no sufficient grounds for positive opinion exists, the ordinary man will do well to suspend judgment." If these principles were accepted, the "garment of make-believe" would indeed be stripped off.

STATE NEWS ITEMS

Dr. and Mrs. L. M. Jenkins, Miami, announce the birth of a son, David Lynch Jenkins, March 4th, at the Jackson Memorial Hospital.

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Dr. and Mrs. S. B. Forbes of Tampa recently had as their guests, Dr. W. B. Lancaster of Boston and Dr. S. B. Muncaster of Washington, D. C. Dr. Lancaster is past president of the American Ophthalmological Society and the American Academy of Ophthalmology and Otolaryngology.

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Dr. Ralph N. Greene, Jacksonville, addressed a meeting of the local Rotary Club on March 21st. The accident prevention campaign now being conducted by the American Legion and Duval County Medical Society was the topic of his discussion.

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Dr. and Mrs. S. A. Winsor of Pompano were recent visitors in Miami.

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Dr. and Mrs. H. A. McClure of Tallahassee visited relatives in Greenwood the latter part of March.

Dr. and Mrs. Jack Halton of Sarasota were recent guests of Lieut. Commander Quinn aboard the British battleship "Dragon" in Tampa.

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Dr. P. J. Hudson of Inverness visited St. Petersburg and Clearwater on a business trip during the month of March.

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Dr. S. D. W. Light of Miami was a visitor in Key West recently.

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Dr. W. L. Ashton of Umatilla announces the removal of his offices from the Bank building to the Lake County Medical Center.

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Dr. L. M. Anderson, Lake City, just received the following letter from Dr. Olin West, Secretary and General Manager of the American Medical Association:

"Our records show that you have been a Fellow of the Association since the beginning of the Fellowship records, and we are greatly pleased to have the privilege of retaining your name on the Fellowship roster."

* * *

Dr. W. M. Rowlett, secretary of the Board of Medical Examiners, wishes to call to the attention of the physicians of the State that there are now among us many medical impostors. A few are endeavoring to practice medicine under disguise, while others are presenting what appear to be attractive propositions. One of the most brazen acts was recently committed in St. Petersburg by a man giving his name as Dr. H. C. Vierick, who attempted to practice medicine under a bogus license, issued by the old regular board. Upon further investigation, it was found that the original Henry C. Vierick had been dead for several years. The impostor made his exit before a warrant could be issued for his arrest. Doctor Rowlett is inclined to believe that the self-styled H. C. Vierick is no other than Robert Thompson, alias James E. Grant, A. C. Muttart, Dr. A. F. Mulshizer, a recent parole violator wanted in California and who was last heard from as "hitchhiking" to Florida.

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Dr. M. M. Harrison and family of Palmetto were recent visitors at Bradenton.

The annual meeting of the Medical Association of Georgia will be held at Macon, May 9-12, 1933.

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Dr. C. H. Ryals of Grand Ridge was a business visitor at Marianna recently.

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Dr. and Mrs. R. J. Greene of Perry recently spent a week-end in Jacksonville.

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Dr. R. F. Godard and daughter, Martha, of Quincy were recent visitors in Miami.

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Dr. and Mrs. W. B. Moon of Crystal River recently made a business trip to Inverness.

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Dr. W. H. Watters of Coconut Grove left recently for Boston, Mass., where he will spend the summer. Dr. Watters' present address is: 124 Commonwealth Avenue.

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Dr. Ernest B. Milam was an honor guest at the first annual Lake County Products fair and Kiwanis fiesta, held recently at Eustis. Dr. Milam is governor of the Florida Kiwanis District.

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The following doctors have affiliated themselves with organized medicine through their respective county societies and the Florida Medical Association:

Edgar F. Brown, Lake City.
J. Maxey Dell, Jr., Gainesville.
Ricardo Fina, Key West.
L. J. Graves, Tallahassee.
Julio J. Guerra, Tampa.
Allen P. Gurganious, Jacksonville.
Fouad H. Hanna, Miami.
A. J. Harness, Lakeland.
Ruth S. Hart, Winter Park.
Claude Mentzger, Miami.
W. H. Peacock, Wauchula.
Max Pepper, Miami.
S. J. Roberts, Miami.
S. M. Salley, Tallahassee.
Harry Z. Silverman, Miami Beach.
Claude B. Wright, St. Petersburg.

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Dr. H. P. Bevis of Arcadia was a recent visitor in Boca Grande, making a boat inspection.

The Public Relations Committee announces the following broadcasts have been given over Station WRUF, Gainesville, under the auspices of the Association:

March 19—"Progress of Medicine—First Third of Twentieth Century."
April 2—"What We Inherit."

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Dr. G. C. Tillman and daughter, Claire, of Gainesville attended the inaugural ceremonies of Franklin D. Roosevelt at Washington. On his return trip, Dr. Tillman stopped in Atlanta and attended the Southeastern Surgical Congress.

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Dr. C. J. Hurlburt of Bartow has leased the Bartow General hospital for a three-year period. Dr. Hurlburt was formerly superintendent of the hospital while it was operated by the City of Bartow.

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Dr. W. Lee Ashton of Umatilla was recently appointed a director of the Harry-Anna Crippled Children's Home and shortly afterward was elected house physician and manager of this newly opened institution.

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Dr. George Plummer of Key West made a business trip to Miami during the month of March.

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Dr. J. K. Johnston of Tallahassee attended the Southeastern Surgical Congress recently held in Atlanta.

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Dr. and Mrs. W. S. Manning of Jacksonville spent several days visiting relatives at Tallahassee during the month of March.

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Dr. and Mrs. Leland Dame of Inverness spent some time visiting at Riviera, Palm Beach County, recently.

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Dr. J. C. McSween of DeFuniak Springs was a recent business visitor at Pensacola.

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Dr. and Mrs. H. V. Weems of Sebring recently entertained at a bridge party in honor of Dr. and Mrs. Warren Wooden of Rochester, N. Y.

Dr. Jack Halton of Sarasota was recently elected president of the Sarasota Shrine Club.

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The American Association for the Study of Goiter will hold its meeting at Memphis, Tennessee, May 15-17. On the preliminary program for this meeting appear the names of the ablest men of the United States on the subject of goiter. A special delegation from the Association will sail from New York City, July 26th, to attend the International Goiter Conference to be held in Berne, Switzerland, August 10-11-12. Members of the profession are invited to attend the meeting at Memphis and to join the delegation going to the international conference. Those who are interested should communicate with J. R. Yung, M.D., corresponding secretary, Terre Haute, Ind.

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Dr. and Mrs. Harold E. Miller of New Smyrna have returned from a visit with relatives in Savannah.

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Dr. and Mrs. Leland H. Dame entertained their friends at a party and dance at their new home recently.

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Dr. J. J. Guerra, Tampa, is taking a post-graduate course at Brady's Urological Institute, New York City.

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Dr. M. H. Tallman of Miami was recently awarded first prize in the annual "liars' contest" of the Miami Beach Rod and Reel club. Dr. Tallman discussed his "fish with human teeth" and produced an exhibit to support his story. A bright red necktie was the award, which marks him as a champion.

DANIEL L. McSWAIN

Announcement of the death of Dr. D. L. McSwain of Arcadia on the morning of January 28, 1933, came as a great shock to the people of the community whom he had served so untiringly, and to his many friends in the profession throughout the state. A few days before he had collapsed after completing a major operation and eleven days later he died in the same hospital.

Dr. McSwain was a native of Florida, having been born in Lake View in Walton County on July 31, 1870. Though handicapped in securing a medical education by financial difficulties, his perseverance and determination brought him through and he graduated from Tulane in 1899. Soon after this he went to Arcadia where he practiced up to the time of his death, a service of thirty-three years. Two years after he began practice he married Miss Eugenia Henry, who with one son, Dr. Gordon H. McSwain, survives him. During the funeral services all business in Arcadia was suspended and schools and offices closed, a token of the esteem in which he was held in the community in which he lived. Many touching tributes to his skill and faithful service as a physician and to his greatheartedness as a man, were written by his friends and patients and published in the newspapers. A most successful life, indeed, whose ending caused such widespread grief and such universal praise of his character and good deeds.

The board of the Arcadia General Hospital, where he was for many years the dean of the staff, included in their resolutions the following tribute to his memory:

"The city of Arcadia and the state of Florida mourn the loss of this great surgeon and friend of the people. Always avoiding the limelight of publicity and devoting himself unselfishly and wholly to meeting the needs of his host of friends and patients, Dr. McSwain was ever at the call of those in distress. He was loved and trusted by all who came under his skillful hands and wise counsel. He was the dean of great surgeons, the tireless worker, the friend of the poor."

The following resolutions were passed by the DeSoto-Hardee-Highlands County Medical Society:

"Once more in the course of human events we pause as a great man passes from our midst. It has not been that of an ordinary man who has come and gone but a man of extraordinary ability in his profession who gave himself unselfishly for the health of others. Rain or shine, cold or warm, he answered the summons for service. Dr. McSwain had an unassuming disposition and won the confidence of all.

"The passing of Dr. D. L. McSwain is a distinct loss to the community and the Arcadia General Hospital of which he was surgeon and vice-president of board of directors. Many will miss him but none will forget him. His service to his fellow man will always stand out as a fitting monument to his memory.

"*Therefore be it resolved,* that the members of the DeSoto-Hardee-Highlands County Medical

Society extend to the sorrowing wife and family their deepest sympathy in their loss at this time which is also our loss.

"*Be it further resolved*, that a copy of these resolutions be sent to the family, also a copy be sent to the State Medical Journal and one copy be spread upon the minutes of the DeSoto-Hardee-Highlands County Medical Society.

"Allen A. Poucher,
"W. C. Touchton,
"G. F. Highsmith."

ROBERT E. BALDWIN

Dr. Robert E. Baldwin of Tampa died following a surgical operation for duodenal ulcer at the Mayo Clinic, Rochester, Minnesota, on February 2, 1933. He was born in Plattsburg, N. Y., April 26, 1886, and received his degree in medicine at the University of Louisville in 1909.

Following this he served at the City Hospital of Newark, New Jersey, for two years and one year at the German Hospital in the same city. He came to Tampa to practice in 1912. During the World War he served in the United States Army and was stationed at Camp Hancock, Augusta, Georgia. Later he was ordered to Washington for duty in the Surgeon General's office and from there he was transferred to Hospital 34, East Norfolk, Massachusetts.

In 1929 he was placed in charge of the X-ray department of the Tampa Municipal Hospital and was promoted to the position of Superintendent of the Hospital in 1932, continuing with his X-ray duties. The highly efficient manner in which he filled this position is a tribute to his ability, for by his tact and exceptional executive ability he made the hospital into a smoothly functioning machine.

Dr. Baldwin was a member of the Elks Club, the State and County Medical Societies and the American Medical Association as well as the American Radiological Society. He was a very popular man, loved by all who knew him and his loss will be deeply felt among a wide circle of acquaintances.

The following resolutions were recently passed by the Hillsboro County Medical Society:

"Whereas, the Hillsboro County Medical Society has learned of the sad and untimely death of Dr. Robert E. Baldwin, for years one of the most distinguished and cherished members, and

"Whereas, his great work and high achievements as a physician, an executive and roentgenologist were recognized by his colleagues and the medical profession, therefore be it

"*Resolved*, that the Hillsboro County Medical Society has learned with profound sorrow and regret of the death of Robert E. Baldwin, one of its most beloved and distinguished members;

"*Resolved*, that this society desires to place on record its high appreciation of his excellent professional attainments and manly character;

"*Resolved*, that a copy of these resolutions signed by the officers of the Hillsboro County Medical Society be sent to his family and the lay and the medical press for publication.

"Earl H. McRae, President;
"Edward Smoak, Vice-President;
"Chas. Wm. Bartlett, Sec.-Treas.

"Dated February 4th, 1933,
Tampa, Florida."

CONVENTION NOTES

The unique location of the convention hotel, with its unsurpassed facilities for providing widely diversified entertainment, has greatly aided the Entertainment Committee of the Broward County Medical Society, and made possible for them to promise something new, novel and worth while.

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For the golfers, a fine eighteen-hole course at the Hollywood Country Club is available. Green fees will be 75c. A golf tournament will be held under the direction of Dr. H. J. Peavy, chairman of the "Turf Diggers" Committee.

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Dr. Leigh F. Robinson, chairman of the Smokers' Committee, promises that the smoker will be a pleasant surprise. The smoker will be held in the New Recreation rooms on the beach floor at the extreme south end of the hotel, well isolated from the "sonorous melodies" of those who wish to retire early.

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The Surgical Supply Co. of Jacksonville, with branch offices at Miami and Tampa, have donated a genuine leather physicians' Boston bag as one of the prizes for the golf tournament. A similar prize was given by this firm last year and won by Dr. Lloyd J. Netto of West Palm Beach.

For those who wish to fish, guide boats from the Ft. Lauderdale Guide Boat Association will be at the docks in front of the hotel. Special rates from Sunday until the end of the convention have been arranged by Dr. B. F. Butler and his committee.

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Dr. E. M. Hendricks, chairman of the Entertainment Committee, promises that the banquet in the beautiful main dining hall will be an event long remembered, with dancing and a floor show of the highest quality. Bring your wives, sons and daughters to enjoy it.

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Last, but not least, bring your bathing suits. There is direct from-room-to-beach elevator service. A dip in the ocean before breakfast will make you fit to enjoy the day and the excellent scientific program.

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Drs. L. W. Cunningham and W. M. Shaw of Jacksonville have furnished their projecting lantern and screen for use in illustrating papers at the scientific assemblies.

* * *

Buy your banquet tickets as early as possible at the registration desk. This will give those in charge of the banquet an indication of the number of guests for which to prepare.

Complete Program of the Annual Convention begins on Page 434.

Meet your Colleagues at Hollywood May 2nd, 3rd and 4th.

COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

THE BROWARD COUNTY MEDICAL SOCIETY, WHICH WILL ENTERTAIN THE ASSOCIATION AT ITS ANNUAL MEETING NEXT MONTH, HAS STEPPED TO THE FRONT. DUES HAVE BEEN RECEIVED FROM ALL MEMBERS OF THIS SOCIETY FOR 1933. CONGRATULATIONS.

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was held April 7, 1933, at 8:30 p. m., Huntington Club Rooms. The following program was presented:

"Trigeminal Neuralgia: Relief by X-ray Treatment. Case Report," J. H. Lucinian, Miami.

"Sensory Aphasia with Demonstration of Case," P. L. Dodge, Miami.

"Human Sterilization as a Eugenic Measure," Taylor Lewis, Miami.

The April "Bulletin" of the Society contains a good editorial; comments from the Society's president, "On to Hollywood," by Dr. M. Jay Flipse; and medical news by Dr. Scheffel H. Wright, all of which are well written and of unusual interest.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Green Terrace Hotel, Bowling Green, Tuesday evening, March 14th. A banquet for the members of the society and their wives was enjoyed.

DUVAL COUNTY MEDICAL SOCIETY

The following program was presented at the regular meeting of the Duval County Medical Society held April 4th at the Mayflower Hotel:

"Prenatal Care in Regard to the Prevention of Toxemias of Pregnancy," James D. Pasco, Jacksonville.

"Cesarean Section," Ferdinand Richards, Jacksonville.

"Version," S. R. Norris, Jacksonville.

"Forceps," A. D. Stollenwerck, Jacksonville.

The Legislative Committee of the Society, under the able chairmanship of Dr. S. E. Driskell, is hard at work both offensively and defensively in the behalf of organized medicine. They are offensively sponsoring constructive legislation and defensively fighting destructive legislation which might arise from sources ignorant of the best interests of the health of the public and the welfare of the medical profession.

HILLSBORO COUNTY MEDICAL SOCIETY

At a meeting of the Hillsboro County Medical Society, held March 7th at Tampa, Dr. George E. Brown of the Mayo Clinic, Rochester, Minnesota, presented a paper on "Hypertension." The

subject was illustrated with lantern slides. Those present voted this the choice program of the year. Dr. Brown is vacationing in St. Petersburg.

JACKSON COUNTY MEDICAL SOCIETY

The following officers have been elected by the Jackson County Medical Society to serve for the ensuing year:

President—J. B. Dowling, Alliance.
Vice-President—C. H. Ryals, Grand Ridge.
Sec'y-Treas.—Lewis Pierce, Marianna.

Dr. D. A. McKinnon will represent the Society, as delegate, at the annual meeting.

MONROE COUNTY MEDICAL SOCIETY

THE MONROE COUNTY MEDICAL SOCIETY HAS REPORTED 100% MEMBERSHIP DUES FOR 1933.

At a recent meeting the following officers were elected for the ensuing year:

President—Harry C. Galey.
Vice-President—George R. Plummer.
Sec'y-Treasurer—William R. Warren.
Delegate to Convention—George R. Plummer.

PALM BEACH COUNTY MEDICAL SOCIETY

The following are the officers of the Palm Beach County Medical Society:

President—S. W. Fleming, W. Palm Beach.
Vice-President—Vesey M. Johnson, W. Palm Beach.
Secretary—James L. Carlisle, W. Palm Beach.
Treasurer—Frederick K. Herpel, W. Palm Beach.

Drs. Frederick K. Herpel and G. M. Dawson have been named delegates to the state convention, with Drs. W. O. Arnold and L. J. Netto, alternates.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. and Mrs. George A. Dame entertained the Pasco-Hernando-Citrus County Medical Society at their home at Inverness, Thursday evening, March 9th. A full course dinner was served and the occasion proved enjoyable to all members who attended.

ST. JOHNS COUNTY MEDICAL SOCIETY

The following officers have been elected by the St. Johns County Medical Society for 1933:

President—A. C. Walkup, St. Augustine.
Vice-President—Gordon Fletcher, St. Augustine.



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Secretary—Reddin Britt, St. Augustine.
Treasurer—Chas. C. Grace, St. Augustine.
Delegate to Convention—Milton Walton, Hastings.

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

A REPORT HAS BEEN RECEIVED FROM THE ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY, ACCOMPANIED BY 100% OF MEMBERSHIP DUES.

The following officers are to be congratulated for the fine activity shown by this society:
President—C. L. Davis, Okeechobee.
Vice-President—L. L. Whiddon, Ft. Pierce.
Sec'y-Treas.—J. D. Parker, Stuart.

Dr. J. A. Newnham has been chosen delegate to the annual convention, with Dr. G. C. Hardie, alternate.

SEMINOLE COUNTY MEDICAL SOCIETY

THE SEMINOLE COUNTY MEDICAL SOCIETY IS ONCE MORE ON THE HONOR ROLL. DUES FROM 100% OF ITS MEMBERS HAVE BEEN RECEIVED AT THE STATE OFFICE OF THE ASSOCIATION. CONGRATULATIONS.

SUMTER COUNTY MEDICAL SOCIETY

THE SUMTER COUNTY MEDICAL SOCIETY, THOUGH ITS MEMBERSHIP IS SMALL AND WIDELY SCATTERED, HAS AGAIN SENT IN ITS ROSTER WITH 100% OF MEMBERSHIP DUES PAID. YEAR AFTER YEAR THIS LITTLE SOCIETY HAS PROMPTLY TAKEN ITS PLACE AMONG THE SOCIETIES IN THE 100% PAID GROUP.

TAYLOR COUNTY MEDICAL SOCIETY

The following officers have been elected by the Taylor County Medical Society, to serve for the ensuing year:
President—W. J. Baker, Foley.
Vice-President—Ralph J. Greene, Perry.
Sec'y-Treas.—J. L. Weeks, Perry.

Dr. G. H. Warren has been named delegate to the annual convention, with Dr. J. L. Weeks, alternate.



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WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, Inc.

State Editor

Mrs. S. E. Driskell

1410 Windsor Place

Jacksonville, Florida

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Mrs. Eugene G. Peek, President-elect *Ocala*
Mrs. Arthur L. Walters, Vice-President *Miami Beach*
Mrs. Ernest W. Veal, Secretary-Treasurer . . . *Sa. Jacksanville*
Mrs. Wilburn Lassiter, Historian *Gainesville*

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Mrs. J. R. Wells, Public Relations *Daytona Beach*
Mrs. H. Q. Jones, Hygeia *Ft. Myers*
Mrs. S. E. Driskell, Press and Publicity *Jacksonville*

The Women's Auxiliary of Broward County Medical Society extends a cordial invitation to the doctors' wives to attend the State Medical Convention at Hollywood the first week in May. It is with great pleasure we are making our preparations, and we hope to vary our programme to include everyone. We highly recommend bringing bathing suits, as the hotel is on the beach and the water is very inviting.

We feel very grateful, indeed, to our State President, Mrs. Leigh F. Robinson, for her generous cooperation, and she joins us in our welcome.

Madeline Carter (Mrs. D. E.),
General Chairman,
Fort Lauderdale.

* * *

PRE-CONVENTION GREETING

Here in Broward County we are looking forward to the State Medical Convention which will be held at the Hollywood Beach Hotel May 2nd to 4th. The annual meeting of the State Auxiliary will be held the morning of May 4th.

We wish that all of the doctors' wives who attend the Convention would be present at this meeting, whether or not a member of the Auxiliary. We want you all to know what the Auxiliary is doing and to join with us in helping this great organization to grow.

New officers for the coming year will be elected at this meeting and delegates chosen to represent us at the meeting of the Woman's Auxiliary to the American Medical Association. Our nominating committee consists of Mrs. J. M. Irwin, St. Augustine, Chairman; Mrs. E. G. Peek, Ocala, and Mrs. M. Jay Flipse, Miami.

Reports of Standing Committees will be read



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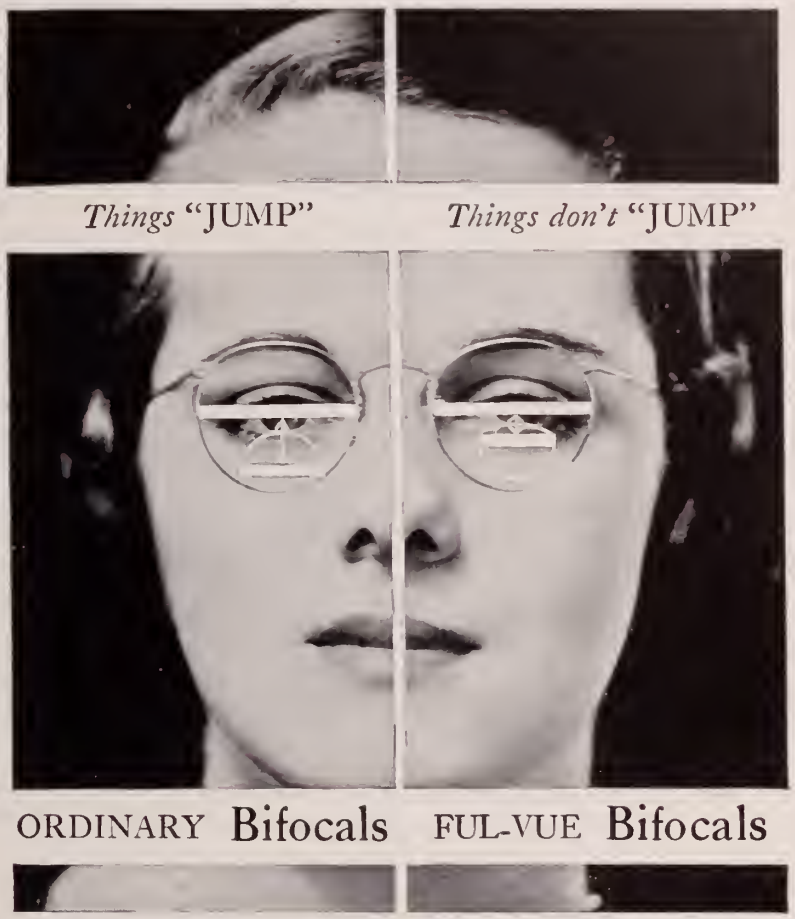
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and those of the County Auxiliaries, all of which will prove most interesting and instructive, showing what has been accomplished this year throughout the State.

Mrs. Leigh F. Robinson, President.

* * *

On Tuesday, March 14th, the Volusia County Auxiliary held their usual dinner meeting in Daytona Beach, having as their guest of honor Mrs. Carl W. Illig, Jr., of Massachusetts, General Federation Chairman of Public Health.

Dr. Arthur J. Cramp, Director of the Bureau of Investigation of the American Medical Association, who came to Florida for a lecture tour under the auspices of the State Medical Auxiliary, was the honor guest of the Volusia County Medical Society.

Following the dinner all adjourned to the Palmetto Club where under the joint auspices of Society and Auxiliary, Dr. Cramp made an amusing and interesting talk illustrated with lantern slides, which every one enjoyed.

On Wednesday, Mrs. J. Ralston Wells, State Chairman of Public Relations, carried Dr. Cramp to Avon Park where he addressed the convention of State Federated Clubs.

Dr. Cramp then went to St. Petersburg where he spoke Thursday under the auspices of the Pinellas Auxiliary.

* * *

From the Pinellas Auxiliary comes a splendid report of their Public Relations work such as distributing to civic clubs A. M. A. posters on baby clinic work—feeding of infants and children, prenatal care, etc., and the A. M. A. "radio health talks." They are also contacting the various clubs in the county asking for a place on some program where they might furnish some one to speak on the County Health Unit Plan.

* * *

The Alachua Auxiliary holds monthly luncheon meetings. They recently had one benefit luncheon to pay for some Hygeia Subscriptions.

* * *

The Duval Auxiliary met Thursday, March 2nd, in the Hotel Mayflower with a large attendance.

Dr. J. Knox Simpson, president of the Duval Medical Society, was guest speaker and made an interesting talk on "Present Economic Conditions and Their Effect on Doctors and Their Families."

* * *

From our National President, Mrs. James F. Percy, comes a letter saying that it is not too

(*Continued on page* 460)

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Arrangement of Exhibits.—The management will provide skeleton booths as indicated in diagrams, also signs of uniform style. No interference with the light or space of other exhibitors will be allowed.

Exhibitor is responsible for damage to property. No signs or other articles shall be posted, nailed, or otherwise attached to any of the pillars, walls, doors, etc., in such manner as to deface or destroy the same. No attachments can be made to the floors by nails, screws, or any other devices that would in any way damage or mar them. All space leased subject to these restrictions.

Restrictions.—Exhibits should be confined, as far as practicable, to special articles, articles that are new, unique, or particularly attractive and scientific in character.

No proprietary drugs, chemicals, or therapeutic agents that do not comply with the rules of the Council on Pharmacy and Chemistry of the American Medical Association or which have not been accepted by the Council for inclusion in "New and Non-official Remedies", can be exhibited, distributed, or in any way advertised in the hotel. (For copy of official rules of the Council on Pharmacy and Chemistry, write A. M. A.)

No medical journal or publication can be exhibited that contains advertisements of drugs, chemicals, or any therapeutic agents which do not conform to the rules of the Council on Pharmacy and Chemistry of the American Medical Association.

Irregular Canvassing and Distribution of Advertising Matter.—Solicitation of business or conferences in the interests of business except by exhibiting firms, is prohibited. Canvassing by exhibitors outside of their booths is also forbidden. Circulars or advertising matter of any description cannot be distributed, excepting from the Exhibitor's booth.

Exhibits of Electrical and Radiographic Apparatus.—Machines and apparatus operated by electricity must be shown as "still" exhibits. Practical demonstrations of X-ray apparatus and accessories or of any noisy apparatus of any kind will not be permitted. No objection will be made to the utilization of electricity for illuminating purposes or for operating smaller diagnostic instruments and electro-therapeutic apparatus which are noiseless.

Subletting of Space.—No subletting of space will be permitted. Each firm represented in the Technical Exhibit must sign the regular form "Application for Space in the Technical Exhibit." Any person or firm subletting space as well as the one purchasing space, will be subject to eviction. No refund will be made for space reserved.

Uncontrollable Eventualities.—The Florida Medical Association, Inc., will take all reasonable precautions against damage or loss by fire, water, storm, theft, strikes and other emergencies of that character, but does not guarantee or insure the Exhibitor against loss by reason thereof.

Cooperation of Exhibitor Requested.—The foregoing regulations with reference to exhibits have been formulated for the best interests of exhibitors and the hearty cooperation of our patrons is requested. All points not covered are subject to settlement by the management.

Space is leased with the understanding that the Exhibitor will hold the Florida Medical Association, Inc., harmless from any or all liability which results from any cause whatsoever within the control of said Exhibitor.

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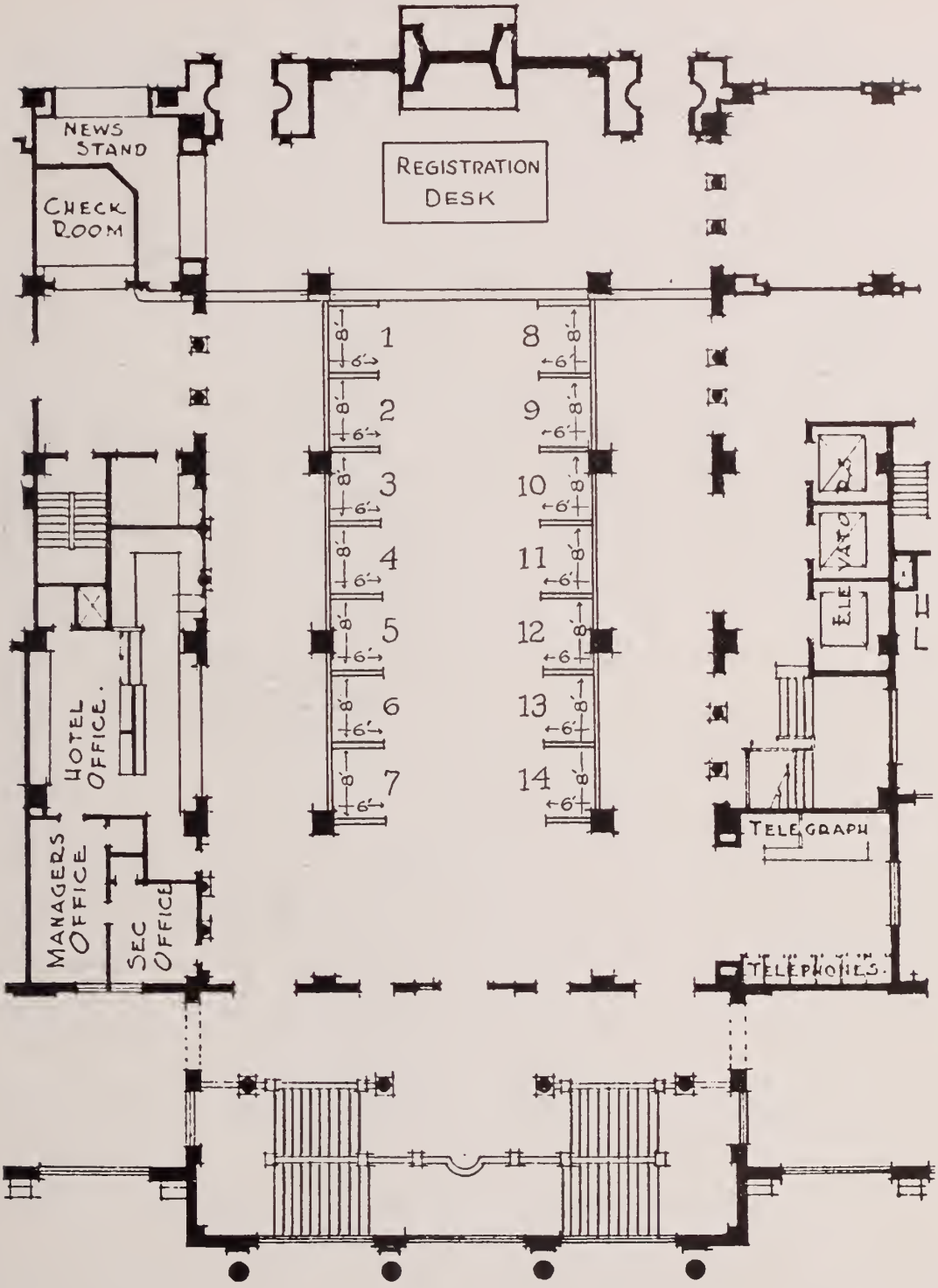
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6	$35.00
9	$35.00
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11	$35.00
12	$35.00
13	$35.00

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Milwaukee, the twelfth most populous city in the United States, situated on the shore of the great inland sea—Lake Michigan—is an ideal convention city, and a splendid program of sightseeing and amusement is being arranged, as well as a most practical and inspirational meeting.

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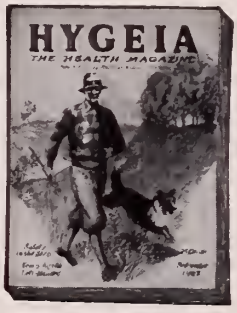
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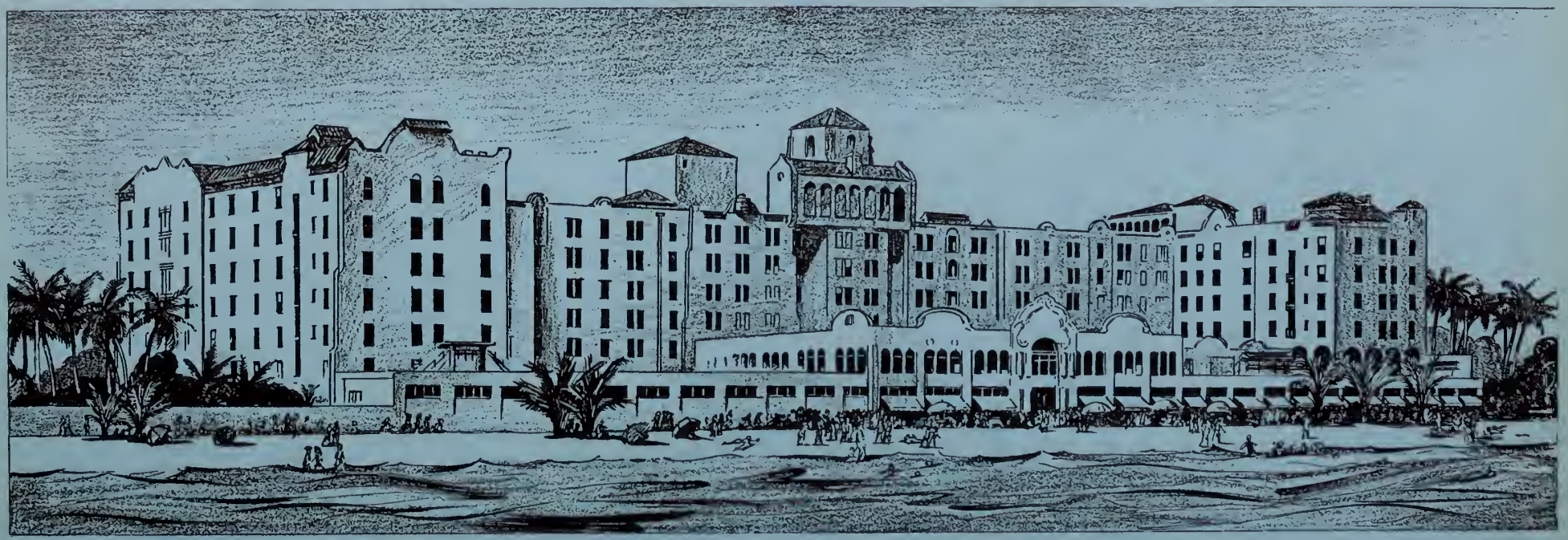
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SIXTIETH ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION

MAY 2, 3, 4, 1933



Hollywood Beach Hotel, Convention Headquarters

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THE JOURNAL
— OF THE —
Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XIX
NO. 11

Jacksonville, Florida, May, 1933

Yearly Subscription, $3.00
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MAY 29 1933
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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

NEXT SESSION American Medical Association, Milwaukee, June 12-16, 1933

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XIX | Jacksonville, Florida, May, 1933 | Number 11

President's Address*

GERRY R. HOLDEN, M.D.,
Jacksonville.

The Florida Medical Association is sixty years old today; a long and honorable existence. All of the earlier records have unfortunately been lost but we can well imagine what those first meetings must have been; sedate gatherings of dignified physicians, men of importance and authority in their various communities. Such was almost the universal position of doctors at that time.

At their annual sessions the discussions were probably limited, for the most part, to scientific subjects, and their membership probably represented but a small part of the entire profession of the state. From the later records which do remain to us, we know that always there has been a considerable percentage of the profession not members of our State Association. Fortunately this condition is now improving.

In 1924 Dr. H. M. Taylor, in his Presidential address, compared the membership of our Association with that of several other Southern States and showed that but 40% of the profession in Florida belonged to our State Association. I have brought that analysis up to date and find that, while we now share with Georgia the doubtful honor of still having the lowest percentage rate of membership in this group, still our increase in membership during this period has been great, greater than that of any other state except Mississippi. The table below shows the conditions as they existed at the time of Dr. Taylor's analysis and as they are at present.

State	Percentage of enrollment in 1924	Percentage in 1932	Increase
North Carolina	70%	72%	2%
South Carolina	53%	66%	13%
Georgia	57%	60%	3%
FLORIDA	44%	60%	16%
Alabama	72%	70%	*
Mississippi	48%	68%	20%

*2% decrease.

Until very recently our Association has had few activities other than those of a scientific nature. To be sure it was instrumental in establishing the State Board of Health in 1889. Also it has always been interested in medical legislation. It was responsible for the bill which created the regular board of medical examiners in 1905 and the so-called composite medical examining board in 1921. In 1923 it sponsored constructive legislation regulating the sale of caustic preparations. It is interesting to note here that at the time this law was passed, only Pennsylvania had such a law; while now these regulations are in force in every state in the Union. Through them the death rate from accidents caused by such preparations has been very greatly lowered.

But except for such legal activities its work, as I have said, has been centered almost exclusively upon scientific matters.

During the last few years, however, there has arisen in our Association a certain feeling that the scope of our activities should be broadened.

In 1930 we accepted the thought offered us by President Dozier that the time had come for us to drop our traditional attitude of isolation, to reach out and contact the public directly, so that the public might have more nearly correct ideas about medicine and medical thought. Although the Association did at that time vote to carry on this publicity work, it is undoubtedly true that some of our members were not in sympathy with the movement, while others were certainly luke warm. Their feeling was that the State Association should confine itself as strictly as possible to scientific work and that our relations with the public, and our attitude to the public, were not suitable fields for the activities of our organization.

I feel sure that the number of men who have that feeling today is much smaller than it was one year ago, and a great deal smaller than it was when President Dozier delivered his memorable address at Pensacola. During the last year we have seen our profession assailed from many sides, our sincerity doubted, our system of ethics

*Delivered before the Sixtieth Annual Meeting of the Florida Medical Association held at Hollywood, May 2, 3, 4, 1933.

ridiculed, and our very position in the complex fabric of modern social life questioned. To those of you who think these statements extreme I would cite not only the many recent sensational novels, whose universal theme is to depict the average doctor as a slimy racketeer, and to the various scurrilous articles in muck-raking magazines, but also to those sincere articles in magazines of the better type which attempt to show that we are unfair to the paying public in our charges and neglectful of those who cannot pay. Finally, I would refer you to the report of the Committee on the Costs of Medical Care, a committee whose sincerity, whose integrity, and whose knowledge along sociological lines cannot be questioned. Yet this committee, whose majority report ignores entirely the assistance which organized medicine could give in solving social problems, advocates a socialistic scheme of State Medicine.

During the past year it has been my great privilege to attend the meetings of many county medical societies throughout the state, as well as numerous less formal gatherings of our membership. I have listened with interest and profit to numerous discussions on questions of medical economics, state medicine, and the present position of our profession from the social and political standpoints.

I want this morning to consider a few of those problems which this experience has led me to believe are of paramount interest and importance to the members of our Association.

Probably the activities of the irregular and the unlicensed practitioner are to the minds of most of us among the major problems with which we have to deal. For many years we have attempted to control this situation by legal methods. There is no need for us to consume time at the present by going into the history of these efforts. The fact that today we have unlicensed practitioners practicing in defiance of law does not argue that they were, therefore, wasted efforts. The trouble lies in lax enforcement of existing laws rather than in deficiencies of the laws themselves. Yet no matter how lax this enforcement may seem to be at times, we are infinitely better off with these laws than we would be without them. It may be some solace to our feelings when we realize that the situation in Florida is probably no worse than it is in many other states. For example, the Chiropractic is not licensed in New York State, yet it is said that there are some 1,400 chiropractors practicing in that state. Moreover, in the country at large, the great majority of all unlicensed practitioners arrested under medical practice acts are set at liberty with, at the most, nothing more than a nominal penalty.

Apparently if the public wants to employ the services of unlicensed or irregular practitioners it is as hard to stop it as it is to stop bootleggers from selling liquor when people want to drink.

Personally, I do not believe that legal methods are going to accomplish very much more than we are getting now. If conditions are to be improved it is much more likely to come through a non-legal approach to the problem.

For a discussion on this subject, as well as that of the healing cults in general, I would refer you to Publication No. 16 of the Committee on the Costs of Medical Care. This is a most valuable monograph and I am quoting freely from it in discussing this subject. Also I would urge that those of you who have especial interest in this subject study the Florida laws which govern the operation of not only the composite medical board but also the osteopathic, chiropractic and naturopathic boards. Copies of all of these laws may be obtained from our Business Manager, Dr. Stewart Thompson.

The non-legal method of controlling the cults has many advantages in its favor. While it is slower than the legal method at the same time it is more certain to obtain results in the end. Moreover, while under the legal method only those cults which are not licensed by state law are affected, the non-legal approach covers them all. There is another great advantage in that the methods used are not only of value in controlling the cults but also tend in other ways to give results that are of advantage to our profession.

In considering this method it is first necessary to find those factors which seem to account for the success of the cults in attracting and holding patients. Then we must not only regulate our own activities so that we are in position to give the public everything that the cults can give, but we must also educate the public to a realization of the basic differences between cultist theories and scientific medicine, so that it can appreciate the advantages offered by scientific medicine.

The first of these factors which we will consider is the type of patient which frequently consults the cultist. Often they are not the sort of case that the average doctor cares to bother with. Many are neurotics, others are cases of incurable

or chronic conditions. Many of them have had more or less treatment from regular physicians without result, or at any rate without any hope of relief being extended to them. There are, of course, many such cases in every community. Unwilling to give up all hope, always ready to try anything once, they form a fertile field for the activities of the irregular, the cultist and the Christian Scientist.

Undoubtedly many patients are attracted to irregulars by their advertising. It is remarkable that many otherwise intelligent people often do not realize that the type of advertising indulged in by the majority of such healers at once stamps them as unreliable. The success of this method of attracting patients is demonstrated by the results obtained by the wandering cultist who settles in a city or town for a few months and carries out an intensive advertising campaign from the beginning. He immediately seems to acquire a clientele which, while it may be only temporary, is often astounding in its numbers.

The methods of cultists are often more acceptable to patients than are those of physicians. From the patient's standpoint, the main point of interest is relief for his pain or disability. Fundamentally, he is not interested in the diagnosis. Neither does he want a painful or expensive treatment. He wants to be cured of what ails him with as little pain and as little expense as possible.

In obscure cases, therefore, the cultist often has a great initial advantage. He gives a diagnosis which sounds reasonable to the untrained mind of the patient without first subjecting him to a tedious, painful, expensive series of diagnosis procedures. He institutes a treatment immediately which in all probability is much more agreeable to the patient than that of the trained practitioner, and so here again the cultist scores.

Finally, that which is very important in contributing to the success of the cultist is the inability of the average person to understand what the foundations of medicine actually are and how greatly they differ from those of the cults. He does not realize that medicine is founded on scientific facts, accepting as truth only that which can pass the most rigid tests. Nor does he realize that every cult is based upon some fantastic theory of disease; theories which are in every case contradicted by established scientific knowledge. A doctor is to him a doctor and the difference between the regular physician and the cultist lies, as far as he goes, in the different methods which each uses to cure his ailments.

These are probably the more important of those factors which tend to make certain patients seek the services of the cults in preference to our own. When we examine them critically we find that the cultist really has but one weapon which we cannot use. He is not bound, as we are, to be accurate in his work and conscientious in his statements. With that exception he has no advantage over us while the resources of modern scientific medicine, if we want to use them, give us a powerful advantage over him. Why, then, do the cults flourish?

Frankly, I believe it to be in great part because they are using certain methods and lines of approach we dislike to use, although it would be perfectly proper for us to do so if we so desired.

Consider the various forms of physio-therapy in common use by so many of the various cults and the psycho-therapeutic methods of the Christian Scientists. It is useless to deny their value in suitable cases. Yet there is a great hesitancy on the part of most of us to adopt them. Right there we are playing into the hands of the cultists who are getting results with them. When we wake up, make such measures a part of the armamentarium of everyday medicine, we shall then take away from the cults one of their strongest weapons.

The second point of our weakness is the attitude of the average doctor toward neurotic, chronic and incurable cases. To most of us they are undesirable and unpleasant. After we have sent them away with a few stereotyped words of advice and a prescription for a placebo we have only ourselves to blame if we find that the Christian Science healer or the electro-therapeutist is treating them with good results. Our attitude should be radically changed. We should get the patient's viewpoint. To us his complaints may be nonsense, perhaps. To him, they are real. The cultist adopts his point of view and treats him from that standpoint, not from the standpoint of diagnosis, and often gets results satisfactory to the patient.

The cost of diagnostic procedure is important not only in this matter of combatting the cults but also in giving proper care to patients of limited means and in answering criticisms of our profession which are made in all sincerity. We are told that our methods, whereby a patient is referred from one specialist to another with ever-

increasing medical bills, are antiquated, cumbersome, entail reduplication of trivial details, and cost too much. There is a great deal of truth, oftentimes, in these statements. Yet under our present system of practicing medicine it seems unavoidable.

Apparently the only answer to this problem is some form of the clinic or group system, whereby a number of men do cooperate in one way or another in their practice. The clinic idea has not been especially popular among us. It has, of course, been grossly abused at times. We are also individualists and have an innate objection to submerging in any way this individualism. Nevertheless, I believe that we should overlook these objections and develop this system of practice. Of course it has many forms. It does not necessarily have to include direct commercial connections. Much can be done by friendly and mutual cooperation. Overhead expenses of practice can be greatly cut; red tape and lost motion eliminated. It is impossible here to develop this idea of group practice in its many aspects but it can be stated that the fundamental requisite of all such plans is a feeling of friendliness between physicians; a recognition of our common problems, and an earnest desire to get together to solve them without jealousy or mental reservations of any sort entering in.

The use of publicity by advertising and spreading broadcast announcements of their healing skill is more difficult for us to combat, but it can be done.

There exists a tremendous demand on the part of the public for medical and health information. The more intelligent the public becomes on such matters, the less likely it is to believe the assertions of quacks. Medicine is today in many ways disseminating such information, and the general knowledge on such subjects has risen immeasurably in the last 25 years.

Moreover, we can and should actually use advertising media to teach the public the facts about medical science. The newspapers, the radio, the moving picture screens, all are media which can be properly used in certain ways. Practical application of this was made in Dallas, Texas. The city was overrun with irregulars. The county society began a deliberate campaign of education, using all media mentioned above. The results were amazing. It is said that after a period, the great majority of the irregulars moved out of town; their market was gone.

Our Public Relations Committee has done excellent work along this line by radio broadcasts and a limited amount of newspaper releases. The work can and should be immensely broadened. Each large county society should have its own public relations committee, working in conjunction with that of the State Association. Meetings and conferences between these county society committees and the committee of the State Association should be held. Paid advertisements of the proper sort in the newspapers would probably be a most fertile field for this work. A series of medical talks arranged by such county society committees could be arranged before the various lay organizations with an interchange of speakers between various county societies. I believe that an extensive, well-balanced plan of public education would prove the strongest weapon which we would have in this problem of control. And here the Woman's Auxiliary could be of the greatest help to us in arranging for these meetings and in staging them.

These, then, are some of the lines along which we must meet the irregular. In the words of Olin West, Secretary of the American Medical Association, "everything depends on the 'delivery of the goods' by the medical profession itself." If we can give those patients services that will satisfy them as well as those services which the cultist gives them, and if we can convince them that scientific medicine offers them in the end a better form of treatment than that based upon some cultist theory, we will go a long way toward achieving our end.

The next topic which I wish to discuss is "What action, if any, shall the members of our Association, either as county societies or as individuals, take toward the question of supplying medical services to those of the indigent and limited income class."

This problem we have always had with us. In the past the profession has settled it by giving its services free when it had to do so while it made its living by getting what it could from those who would and could pay. Not a very satisfactory or business-like way of doing things, of course. But then, doctors are not business men. If they were, they probably wouldn't be doctors.

Nevertheless, this system has existed for countless generations and, until within the last few months, we took for granted that in this country at least it would continue. Now, however, we

are suddenly told by social science that our system is antiquated and out of date; that economic activities of medicine have not kept pace with its scientific development. Under the old system the costs of the various forms of medical services are so unequally distributed that on the one hand many patients cannot receive all that medical science may have to offer, while on the other those providing these services cannot, in many instances, be properly repaid for their efforts.

I have neither time nor inclination to discuss this subject as a whole. But I do want to consider one or two angles of it which are of interest to us as Florida physicians. The problem of supplying service to the low income group has two sides: first, one of theoretical interest to the social worker—how can these people get the services; the second—of practical economic interest to us—how can our profession supply this service and also derive some income from a class which as a rule pays little or nothing to us. The socialistic theorist, of course, advocates some sort of state medicine. This our profession will never voluntarily accept.

In many parts of the country, efforts are being made by organized medicine to meet this problem by supplying such services under the so-called group payment or installment payment plan. It is, in effect, a health insurance whereby each member of a large group pays a certain monthly sum to the controlling organization in return for which, when illness occurs, the insured has the right to medical, and in some forms, hospital services.

Detailed discussion of this plan is unnecessary here. Numerous schemes have been discussed and analyzed in nearly every issue of the American Medical Journal for many months. Most instructive and interesting bulletins have been issued by state and county societies. Especially valuable are those issued by the California Medical Association and the Milwaukee County Medical Society. Moreover, such systems are already in operation in some parts of the country.

Theoretically there is no reason why such plans could not be operated by county medical societies with benefit both to the physicians and the clientele affected. Practically, the difficulties are enormous, so great that no county society in the Southeast, as far as I know now, has yet been willing to attempt it.

There are certain fundamental rules which must be adhered to if such schemes are to be operated with justice to all members of the profession. As an excuse for my apparent presumption in laying down such rules, I would say that they are not original but are principles which have been laid down by various groups of organized medicine.

(1) The beneficiary group must be limited strictly to people of certain limited income.

(2) The plan must be sanctioned by the county medical society.

(3) Ultimate control must be vested in the county medical society or its representatives.

(4) It is not incumbent on any member of the county society to join the group rendering services unless he so desires, but no group of members can band themselves together to render such service unless such action is approved by the county society.

All these points are important and absolutely necessary if such a plan is to be carried out fairly and ethically. This plan is intended for people of limited income who under ordinary circumstances would pay a physician little or nothing. If, then, the income limit is too high an injustice is done to the profession. In many plans, the top limit of income is set at $100.00 per month for a single man with increasing amounts for married or family men varying with the number of dependents.

The plan must be sanctioned by the county society and controlled by the county society. It is well known that health insurance plans controlled by commercial companies exploit the profession and give the poorest sort of medical service at the highest rates.

To my own mind this does not mean that some business details could not be well handled by certain high-minded ethical insurance companies, companies whose past record shows a sympathy with the medical profession and a desire to cooperate with it. This suggestion comes from Dr. Field, Chairman of the Economics Committee of the Duval County Society, and I believe that it is a good one. Such cooperation would give a county society the benefit of a trained business organization to handle certain details but, with the county society in actual control, would avoid the evils attendant upon the ordinary type of health insurance by commercial insurance companies.

Even though a county society adopted such a plan, it should not be compulsory for every member of the society to join the group rendering service. That would be manifestly unfair. But, on the other hand, since the plan is to be executed and carried out by the county medical society, no group either large or small would be justified in organizing such service on its own initiative. Such a group would be an outlaw organization, not to be recognized by the county organization.

These ideas are, of course, revolutionary. Theoretically, I do believe that under certain conditions they are practical and if they can be carried out I do believe that the ultimate result would be beneficial not only to a certain group of the public, but also to the medical profession itself.

Another fertile topic for discussion along this line of medical economics is the possible infringement upon our practice by various private charities and our attitude toward such enterprises. Among these activities are those clinics organized and managed by various philanthropic and semi-philanthropic organizations, civic clubs, fraternal bodies, social clubs, religious denominations, etc. We must realize that the motives behind these clinics are, as a rule, genuinely altruistic, and that many, probably the majority of them, are worthy of our support. Yet even the best of them may at times infringe upon our private practice, while others we feel are unnecessary from the standpoint of the public welfare and positively detrimental to the best interests of our profession.

Such abuses, it would seem, could easily be avoided by a better understanding between our profession and the various welfare agencies. Clinics should not be established until conferences between organized welfare agencies, the State Board of Health and the various county societies have demonstrated that they are needed. In operation they should be limited to the indigent and should function only with the assistance of the county societies.

Of far greater importance than any inroads which such philanthropies may make upon our professional incomes is the consideration of the basic stimuli which inspire the formation of these clinics in the beginning and the present relation of these forces to our professional welfare.

The original thought in such charity work was that those more blessed by fortune should help those less favored, the sick needy poor. Recently this fundamental idea seems to be changing. Now it is almost as if citizenship in itself gives the indigent the right to expect not only medical service but every other sort of service and that society at large, the state, is obliged to give it.

Nowhere are these conceptions of social obligations more taken for granted than in the report of the Committee on the Costs of Medical Care. Both the reports, majority and minority, admit that the fact that a certain proportion of our population is not receiving everything that it might get in the way of service in itself constitutes a problem. Yet our death rate is the lowest in years and it is also a fact that the majority of people are getting better medical service today than they ever have before. Surely any of you who practiced in Florida 25 years ago can vouch for this statement as far as our own state goes.

Whether we like it or not the socialistic tendencies which inspired this viewpoint in both reports are here and are here to stay. Whether or not our profession ever becomes completely socialized in this country will depend to a large extent on the answer which our profession itself makes to this problem.

Many of us have wondered why organized medicine seemed to have so little authority in the deliberations of this committee. We wonder why the organization of the American Medical Association was ignored almost entirely when schemes to solve the problem were being formulated.

While there probably are many causes for this neglect one important reason may be the customary attitude of the physician towards social science, welfare and relief work, and public health. As a rule we acknowledge their value, we concede that they should be carried on, but when it comes to personal participation we usually feel that some other man is much better fitted than we are to take an active part. This attitude is really rather a natural one for us to assume. After working all day with ailing humanity as individuals, it is hard for us to get up much enthusiasm over the sorrows and ills of humanity in general. Our interest is in the concrete problem rather than in the abstract.

By this general attitude we have lost the grip which we might otherwise have had in philanthropic work and have allowed this control to pass for the most part into the hands of theorists who have no practical connection with the medical side of the situation and do not feel bound to extend to the physician any especial consideration.

Recently I have come into frequent contact with numerous welfare and public health agencies. I have been privileged to attend numerous meetings and conferences of such organizations and have listened to many discussions by their membership. I have been impressed with their readiness to cooperate with the medical profession in their work. I believe that we will be met more than half way if we, as a profession, assume an interest in their work. Not only is it our duty as physicians and citizens to actively cooperate with organized philanthropy, but as a result we shall be in a much better position to control the situation and protect our profession whenever the need arises.

So much, then, for our relations to private charity clinics. Of greater practical importance to us are the services which we, as staff members, supply to hospitals, and especially those hospitals which are supported by taxation, city and county institutions. For years we have been giving those services free of charge. There is a widespread sentiment against this practice. While it is conceded that such staff positions are an honor and that the experience is valuable, most of us find that after a while the honor palls and experience means rather a vast amount of uninteresting routine, unappreciated and of little value from the standpoint of experience.

The counties are responsible for the care of the sick poor. These services we render to the county or the city. Every person connected with the hospital from the superintendent down to the dishwasher in the kitchen is paid except the medical staff. Yet when we are debtors to the county or city no regard is paid to all this work which we have given. Our taxes, even our occupation taxes, are assessed against us just as they are against every other citizen. At present there is even a bill which has been introduced into the house which provides that the income of every physician shall be taxed 2 per cent a year.

While the majority of us acknowledge the injustice the remedy is rather difficult to find. Granted that these political bodies should pay the doctors, just how shall it be managed? If we have regular paid staffs for such services, full time men in some of the larger hospitals, with salaries paid to the men directly, the chances are that our hospitals would degenerate into political institutions, with great deterioration in the quality of work supplied to the patients. No hospitals would be able to pay salaries which trained and qualified men would feel that they could accept. The staff places would therefore soon be filled by men whose political abilities were greater than their medical qualifications.

As a remedy for this situation it has been proposed that the county societies contract to supply the entire medical work to such a hospital; that payment therefor be made directly to the county society and not to any individual man. Such an arrangement has many things in its favor. The work could be so divided up among the members that while a competent staff could be on duty all the time no injustice would be done to any individuals. Service would be given the patients while the county society, as an organization, would be placed in a most advantageous position.

Such arrangements need not apply only to the larger counties either. At present Lake County, with 17 members, has entered into arrangement with its county commissioners to supply a large amount of the necessary services to the county charges under a system similar to this.

I am sure that during the course of my remarks my conception of what the county society can be, should be, has been made clear. County societies are the foundation of our state organization. Indeed the State Association is in many ways but a clearing house, as it were, for these county societies. The State Association can prosper only as these individual societies prosper.

The conception of the county society as outlined by Dr. Freeman of Ocala in a paper recently read before the Marion County Society probably represents the ideal toward which we should strive. By the use of monies derived from services rendered by the society to various clinics we would have the first essential toward this goal. With such an income county society dues would be unnecessary. Also State Association dues and occupation taxes of members would be paid by the society.

I would visualize the active society as one in which all members worked together, discord, jealousy, and enmity abolished. This is of greatest importance and a fundamental. Such a society would own its own building in which not only would there be offices available for members at lower than commercial rents. This building would contain also not only a convention hall but club-rooms intended exclusively for social purposes. It would have its own telephone exchange, nurses' directory, run without expense to nurses. The society would have an active public relations

committee looking after the necessary publicity and an economics committee which would maintain a collection agency, a financing bureau and a credit bureau. The members of this society, housed for the most part in one building, contacting each other frequently in a social way would approximate a college fraternity in spirit. They would gladly and without professional jealousy cooperate with one another in a professional way, thus assisting one another in practice and by practical methods study to cut down the cost of diagnostic service.

An impossible ideal do you say? I do not believe it. We have right now in our state certain societies and certain groups of men in some societies who are co-operating in many of the ways that I have just mentioned. They are finding life much more pleasant and incidentally their practices more lucrative than under the old system of individualism and jealous competition. With an income derived as has been outlined by services rendered by the society as a whole all of the material things just outlined could be easily obtained. And with these material things there should come those other benefits; friendliness, good will, muutal co-operation.

Gentlemen of the Florida Medical Association, I commend to you my ideal of the county medical society. I trust that you will not consider it an impossible dream. I do hope that we may see, in the near future, its feasibility proved by such societies in actual operation.

Before concluding this talk, I want to express my great appreciation for the co-operation which the other officers of the Association and the members of the various committees have given during the past year.

These gentlemen have been called upon frequently, not only to give their advice, but also to make many trips in the interests of the Association. Ignoring all questions of personal expense and inconvenience, each man has invariably given a whole-hearted response to the call made upon him.

Also, in order that the matter will be clearly understood, I wish to add that during the past year, as has been the custom of this Association in the past, neither the president or any of the officers or members of the various committees have received any money from the treasurer of the State Association to defray the expenses incurred in making trips.

Ladies and gentlemen, I thank you.

ADDRESS OF LEGAL COUNSEL*

SAM MARKS, Jacksonville.

Once upon a time I had a notion that the weight of the world rests upon the shoulders of the legal fraternity. That idea is now somewhat modified and I am confident that the medical fraternity carries at least half of the burden.

We won't give the bankers any credit because they don't give us any.

So if we (doctors and lawyers) are such good fellows and so important in the general scheme of things, it behooves us to stick pretty close together; and, very confidentially, it was for that reason that your officers decided the Association should have advisory counsel—it wasn't that you were in any particular legal difficulty or expected to get in any or that we could have gotten you out of it if you did—it was just a sort of get-together arrangement, an extension of the good hand of fellowship between the professions. I consider that the Bar Association is more in need of medical advisers—at least so long as the 18th Amendment stands unrepealed.

Now, while we are talking about our good qualities, (we will let the patients and clients tell about our bad ones) I take this opportunity of expressing admiration for the vast amount of benevolent work you do for the charities and for general civic betterment. In that respect your efforts so far outshine those of the lawyers that there is no room for comparison. I understand the charity patient often gets a better deal than the man who pays, thus proving that the poor man benefits by being off the gold standard.

I was not assigned anything in particular to talk about today—you may have surmised that already—but it was intimated that in the past your county societies, and at times even your State Association, have had problems to solve of a quasi legal nature; it was said that some of these have eventually found their way into the courts, where satisfaction was not always obtained, and others have just smouldered at home like Maggie and Jiggs in their domestic relations.

When this invitation was extended to me, it was made fairly plain that I was expected to read a paper of some kind—not to make a speech. It is a well-known fact that it is dangerous to suggest to a lawyer that he talk at random. As I got the idea, the paper was to contain anything

*Delivered before the Sixtieth Annual Meeting of the Florida Medical Association, held at Hollywood, May 2, 3, 4, 1933.

we could offer in the way of constructive suggestions, how to make the workings of the Association run more smoothly. It was suggested that we lawyers, being rank outsiders, should be able to get a different slant on your general set-up; I mean different from those who are so closely identified with the work of the Association as to be handicapped by that very fact.

I have seen constructive criticism offered before and it generally appeals in about the same way that the dose of medicine appeals. People have a habit of wondering whether the doctor isn't wrong and whether the advice is really sound —and sometimes they have good cause to wonder. So you can well imagine that I undertook to prepare this paper only after considerable hesitation and with some temerity; I considered it a difficult assignment and still feel that way about it, but being assured that I might come down here and speak frankly and that you probably would not take it very seriously anyway and that I would be guaranteed escape without a major operation, I promised to come and now that I am here would like to say that I appreciate very much the opportunity of addressing you.

So let us see what the facts are and if we can at least (as the diplomats say), agree in principle. In considering the legal status of the medical fraternity in Florida, the first step is to turn to the Florida statutes and see what the lawmakers have done for you to date—I did this and the books show somewhat as follows:

(1) An Act creating the State Board of Medical Examiners.
(2) Another Act creating a State Board of Osteopathic Medical Examiners.
(3) A further Act creating the Florida State Board of Chiropractic Examiners.
(4) An additional Act creating a State Board of Podiatry Examiners. (The Supreme Court recently held this act invalid because the name in the title was spelled Pediatry).
(5) Another Act creating the State Board of Naturopathic Examiners.
(6) Another Act creating the Florida State Board of Dental Examiners.

And, in addition to the foregoing, I noted the Florida Board of Examiners in Optometry, the Nurses' Board of Examiners, the Board of Pharmacy and special statutes relating to registration and the practice of midwifery.

Thus I soon became convinced that the lawmakers have been very active in your behalf; in fact, I began to wonder if they have not been too active. I was somewhat bewildered.

Now I realize that there are a number of different and possibly conflicting schools of medical thought, to say nothing of some religious doctrinal teachings and psychological theories that relate to the healing art; but being accustomed to one basic law regulating admissions to the Bar, I was astonished at the number and variety of statutes controlling the practice of healing.

Upon a further examination of these statutes I began to doubt if they were enacted pursuant to any general or orderly plan; it appeared that the several boards were created at different times by separate and distinct acts of the Legislature, which differ materially in language and in their essential provisions. There does not seem to be any uniformity in regard to the number of members comprising the various boards, their qualifications or the terms for which they hold office. The several boards meet at different times, conduct examinations in different ways and issue certificates according to different standards. The fundamental qualifications of an applicant submitting himself for examination may satisfy one board and yet not be at all sufficient before another board. The fees charged seem to be somewhat uniform but the disposition of them is not. The powers of the different boards in removal proceedings vary as do the methods of procedure. The fines and penalties prescribed by the several Acts to be imposed against offenders range from a minimum fine of $25.00 and no imprisonment in one Act to a maximum of $1,000.00 and five years' imprisonment in another Act.

I began to wonder if these things are as they should be. I realize that you may not be able to frame a single act so complete that its provisions will satisfy all of these various groups; and it may well be that several examining boards are necessary, but should you not have a comprehensive practice act that will be simple and of uniform application in many of its essential features? The variety and complexity of the existing laws tend somewhat to confuse and I daresay some of the problems of the past may be traced to this condition of affairs.

Certainly no one should advocate tearing down the present structure until some satisfactory substitute can be framed and agreed upon; but it would seem that we may look forward to the time when the various branches of the profession and the various boards will unite in preparing a more

uniform practice Act covering the things that are essential and common to all.

It appears from the several pamphlets prepared under direction of Dr. Thompson that you have obtained many official opinions from the Attorney General and I understand that you have in the past on one occasion or another appealed to the courts for relief. Sometimes the practice of one branch of the profession may overlap or infringe upon the rights of another branch; such problems are difficult to solve and when cases of that kind arise we may expect them to be troublesome unless the law defines well the boundary and makes the way plain. One difficulty of the present system is this: That should you obtain a court interpretation or construction of one of the laws I have mentioned, it might well be of little or no value as a precedent for cases arising under another such law, the two being so dissimilar.

Therefore I say that if the several state boards could be prevailed upon to confer and work for the passage of more uniform laws, it is entirely possible that their enactment will go a long way toward solving some of your problems.

Further in regard to these problems, and I am now referring particularly to the problem of maintaining the high standards of your profession and the correction of abuses, it would seem that the solution must come through the local rather than the State or National Associations.

Kipling has well said that "Your calling should exact the utmost that man can give—full knowledge, exquisite judgment and skill in the highest, to be put forth, not at any self-chosen moment, but daily at the need of others."

From what I know of the work of the State Association it is already doing everything possible to elevate the standards and to require that applicants for license be found to possess those essential mental and moral qualifications that will do you credit in the future. This is of course vital, for if you let into the fold those who will flagrantly violate your code of ethics, then you not only bring discredit upon the profession but you will find it a most difficult matter to get rid of them.

But in spite of everything the State Association can do, some trouble will develop—complaints have arisen and will continue to arise. Perhaps some of you may recall the story of Bill Jones who, while in college, studied both law and medicine and found it difficult to choose between the two. Some years later one of the professors met a boy from Bill's home town and inquired which profession Bill was practicing. "Well," said the boy, "I hardly know for the lawyers all call Bill 'Doc' and the doctors all call him 'Judge.'"

Now the chances are that Bill Jones and those like him will never bring your profession into disrepute; for even if they are not successful practitioners, their college training has instilled into them the standards and ideals of the profession. Your troubles will probably come from those of a different class, less educated but more shrewd and ambitious than Bill ever thought of being. Thus from time to time a local Association will report to the State Association that someone in that vicinity is practicing without a license or that some doctor in one branch of the profession is operating outside the scope of his authority, invading the legitimate field of operation of another branch; sometimes it is an act of criminal malpractice that is reported.

The local societies, or some of them, seem to feel that the State Association should prosecute such cases; but even if it had the funds to do so, it could not successfully undertake the correction of such abuses. It might assist, but these things must necessarily be corrected at home or mainly through the efforts of the local society. And it should not be such a difficult job—the statutes provide remedies ample for the correction of such evils. The law is well defined and not too complicated; the procedure is comparatively simple.

In the case of one practicing without a license, it is only necessary to show that the defendant had no license and that he practiced medicine in violation of the statute.

So the law and the remedies for its enforcement are available—the difficulty in most cases arises from lack of proper proof, and this is where the local society must act.

Proof is an elusive thing—it is often difficult to find and sometimes more difficult to hold.

Assuming that you know of some violation of law, either within or without the profession—a condition that you know to require correction: Are you willing to go into court and testify? Possibly so, but most likely not. If it is a fellow practitioner, you do not care to be accused of persecuting him; someone might say that you are acting from an ulterior motive. Many of us shun the publicity of the thing and yet, unless the prosecutor can prove his case by credible witnesses, he cannot obtain a conviction. In resisting a criminal charge, the defendant is entitled to the benefit of every reasonable doubt.

I suppose you have your Grievance Committees—we of the Bar have them and it is not always an easy matter to pass decision upon a fellow practitioner. Due allowance should be made for his honesty, sincerity and for human weaknesses. We try to induce every reputable practitioner to join the Bar Association—generally those in the Association can be controlled better than those out of it. I presume you proceed upon the same theory. In spite of everything that can be done, it sometimes becomes necessary to take drastic steps.

If you would successfully invoke the aid of the law in such cases, we recommend that your local societies appoint committees to contact your public officers who will handle the cases in court, with your State's Attorney, County Attorney and Judges. Frequently these men do not know of your aims or problems. You may well ask them to occasionally attend your meetings. Cultivate their friendship—you will find them ready and anxious to cooperate.

On the other hand, if you do nothing to inform these officers of the workings of your Association, if you fail to give them a proper measure of support, you cannot reasonably expect to obtain the best results. Most of the prosecuting officers, especially those in the large centers, have their hands full; they do not have the time or the facilities for making independent investigations, they ofttimes have to take the law and the facts as the case comes to them, lay these before the court and jury and abide by their decision.

In cases of this kind, the defendant will undertake to obtain the best legal talent. He may, and often does, claim persecution or that the charge brought against him has been instituted by jealous rivals; his friends and attorneys work to influence public sentiment in his favor so, unless you have a well-informed advocate in the solicitor for the State, and unless you lend him your full cooperation, it is quite likely that verdicts of not guilty will often be rendered in cases which you know should have resulted in convictions. People question how such things can happen, but we know that they can and do happen, and it is usually for lack of proper proof.

Now, if you agree in principle with these observations, you have something to think about and work upon; if you disagree, perhaps someone else will advance some better suggestions. From the different opinions will arise discussion and eventually, we hope, unity of thought and agreement of ideas. If that result follows and if it inures to the ultimate benefit of the profession, this discussion may not be entirely in vain.

"Let us, then, be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labour and to wait."

PROCEEDINGS

of the

SIXTIETH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

HELD AT HOLLYWOOD, FLORIDA

MAY 2nd, 3rd and 4th, 1933

The Sixtieth Annual Meeting of the Florida Medical Association was called to order at 1:30 p. m. in the auditorium of the Hollywood Beach Hotel, Hollywood Beach, Florida, by A. B. Connor, Chairman of the Convention Committee. The invocation was rendered by the Reverend John G. King, pastor, Presbyterian Church, Ft. Lauderdale.

Dr. Arthur G. Fort, Delegate from the Georgia Medical Association, a past president of that organization and a past vice-president of the Florida Medical Association, was then introduced and the privileges of the floor extended to him. Dr. Fort made a brief address on behalf of the Georgia Medical Association, and extended an invitation from that organization to the members of the Florida Medical Association to attend their annual meeting. He also requested that as many Florida Doctors as possible attend the Emory Clinics in June.

Dr. Gerry R. Holden, President, then took the chair and called for the reports of officers.

The following joint report of the Secretary-Treasurer-Editor and Business Manager was read by Dr. Shaler Richardson:

JOINT REPORT OF SECRETARY-TREASURER, EDITOR OF THE JOURNAL, DR. SHALER RICHARDSON, AND BUSINESS MANAGER, DR. STEWART G. THOMPSON

To The President and Members of the Florida Medical Association in Session at Hollywood.

GENTLEMEN:

MEMBERSHIP

During the calendar year 1932, the various component societies of the State Association forwarded dues for 927 members as compared with a total of 934 for the previous year. The shrinkage of paid members is therefore only seven. Our report last year showed a total of thirty paid members short of the previous year. The Association is, therefore, to be congratulated on its showing of paid members for the calendar year of 1932 since the actual shrinkage is only 7/10 of 1%. The growing strength of organized medicine is plainly demonstrated by the foregoing figures. If the number of paid members can hold its own under present economic conditions, the interest and activity of organized medicine are certainly growing steadily. It is, therefore, not unreasonable to assume that with more encouraging economic conditions, there will be a natural increase in the number of regular members of our Association.

While the depression has been keenly felt in practically every line of endeavor it is encouraging to note the increasing interest of our members in activities pertaining to the promotion of organized medicine which, after all, benefits each doctor who is practicing medicine. Holding our own in the matter of membership is only one of the many indications of thriftiness in our organization and other reports which will be read before this body will bring out some of the unusual activities during the past year.

Dade County Medical Society holds first place in the number of paid members for 1932. There has been keen rivalry over a period of years between Dade and Duval County Medical Societies to rank first in membership. In 1932, however, the Dade Society took an unquestionable lead with 161 paid members as compared with 139 for Duval.

Fifteen component societies show 100% of their membership dues paid for 1932 which is, indeed, a splendid record. The societies having all of their state dues paid for 1932 are: Brevard, Columbia, Escambia, Lake, Manatee, Monroe, Orange, Pasco-Hernando-Citrus, St. Johns, St. Lucie-Okeechobee-Indian River-Martin, Sarasota, Seminole, Sumter, Taylor and Walton-Okaloosa.

From questions coming to our office it appears that quite a number of members do not realize that if they have membership in their county society and the State Association, they automatically become members of the American Medical Association without additional expense. Just as soon as the Secretary of a county society forwards to the Secretary the state dues of any member, that individual's name is reported to the American Medical Association at Chicago and he is then a member of his component society, the State Association and the national organization.

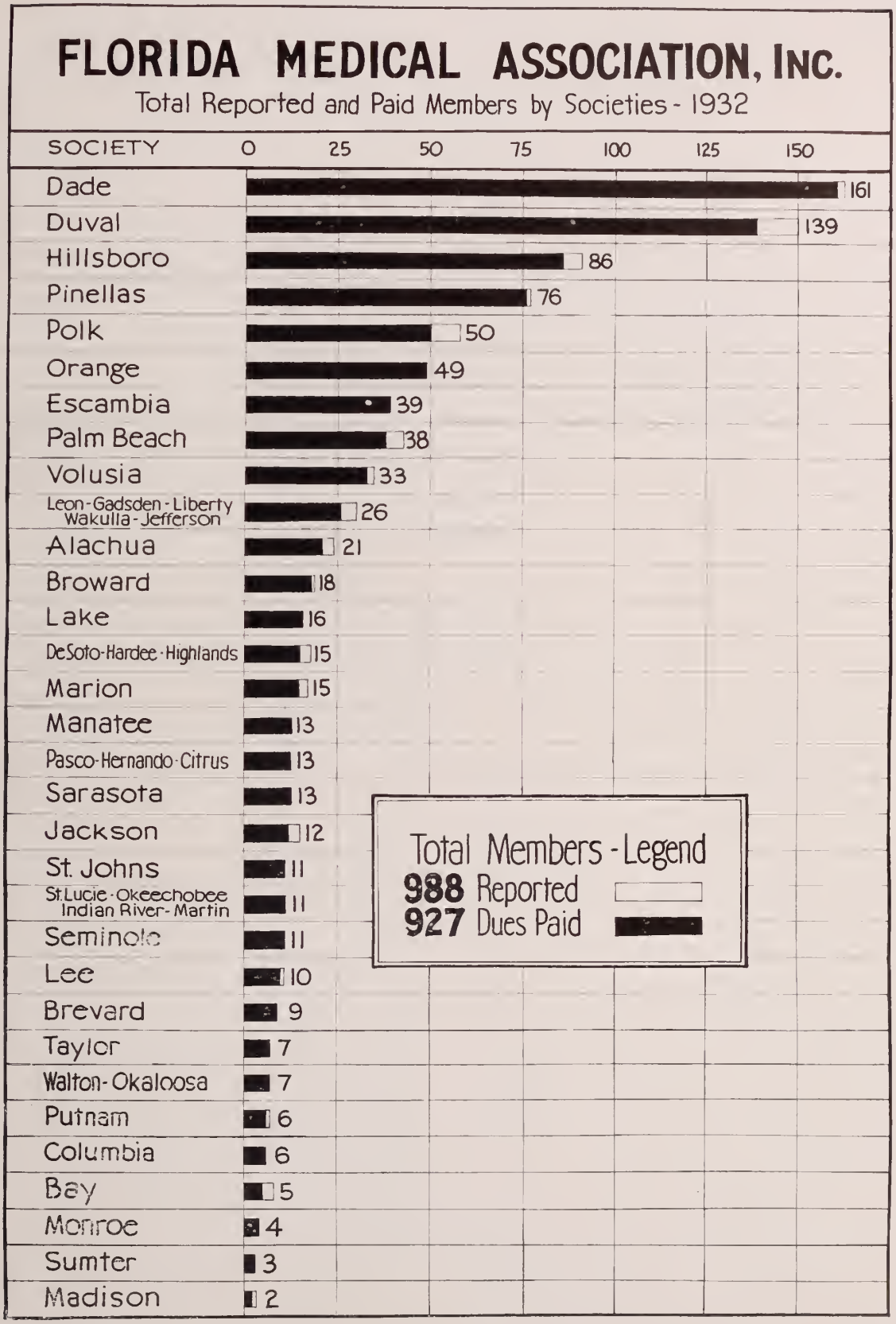
FINANCES

The net income over expenditures amounted to $835.40 during the past fiscal year. The financial condition of our Association is, therefore, sound notwithstanding the fact that income from many sources was diminished on account of economic conditions. Receipts from advertising in the Journal diminished considerably as many firms could not appropriate finances for advertising purposes to the same extent that they had during previous years. Our net loss was $783.99 in receipts from advertising as compared with the previous year. To offset this loss, however, the cost of printing the Journal amounted to $607.57 less than for the previous year. There was also a net saving through salary reductions of $146.69, despite the fact that we were compelled to hire some part time service to assist with the work of the Public Relations Committee and for other additional activities which were put on the business office over and above what could be handled by our regular personnel.

The total receipts during the past year amounted to $11,614.50 and the total disbursements were $10,179.10, leaving a net balance of $835.40.

We have endeavored to explain the financial statement a little more fully this year as a number of our members have mentioned that they could not understand the published financial report in its present form which is necessary to pass our auditors.

The books and records of the Association are open to all members and we will be glad to


FLORIDA MEDICAL ASSOCIATION, INC.
Total Reported and Paid Members by Societies - 1932
SOCIETY
0
25
50
75
100
125
150
Dade 161
Duval 139
Hillsboro 86
Pinellas 76
Polk 50
Orange 49
Escambia 39
Palm Beach 38
Volusia 33
Leon-Gadsden-Liberty Wakulla-Jefferson 26
Alachua 21
Broward 18
Lake 16
DeSoto-Hardee-Highlands 15
Marion 15
Manatee 13
Pasco-Hernando-Citrus 13
Sarasota 13
Jackson 12
St. Johns 11
St.Lucie-Okeechobee Indian River-Martin 11
Seminole 11
Lee 10
Brevard 9
Taylor 7
Walton-Okaloosa 7
Putnam 6
Columbia 6
Bay 5
Monroe 4
Sumter 3
Madison 2
Total Members - Legend
988 Reported
927 Dues Paid

answer all inquiries and take our members through the office at any time.

JOURNAL

Your Journal has been mailed on or before the twentieth of each month during the past year. It is a department of your Association which is of great importance and we feel sure you realize it is no small task to assemble and publish, regularly, the class of Journal you have been receiving. All original articles must be sent to each member of the Committee on Publication for approval and returned before being ready for publication. All broadcasts and newspaper releases, likewise, must be approved by the members of our Committee on Publication. The work of keeping the advertising space full represents a tremendous task and is quite essential to the income of our Association. Through a contract with a clipping bureau service in Miami, we were able to enlarge the news item column. This, of course, was in addition to the news items sent in through the component societies and by individual members. At this time, we urge that every member forward news items as promptly as possible since this department of the Journal appears to draw the attention of the majority of our readers.

The members serving on the Committee on Publication with your Editor are: Dr. Roy J. Holmes, Miami, and Dr. H. L. Bryans, Pensacola. This committee has heavy work during the entire year and should receive special mention for their untiring efforts in reviewing the material that has been submitted to the Journal for publication. Associate editors have been very generous in submitting editorials during the past year and your Editor at this time wishes to publicly recognize their services, which have added so much to the standing of the Journal and the interest of our readers.

Another 10% decrease was secured in the printing price of the Journal and this has been commented upon under the caption "Finances." This 10% decrease, which took effect February 1, 1933, is in addition to the 10% reduction mentioned in last year's report.

IN THE OFFICE

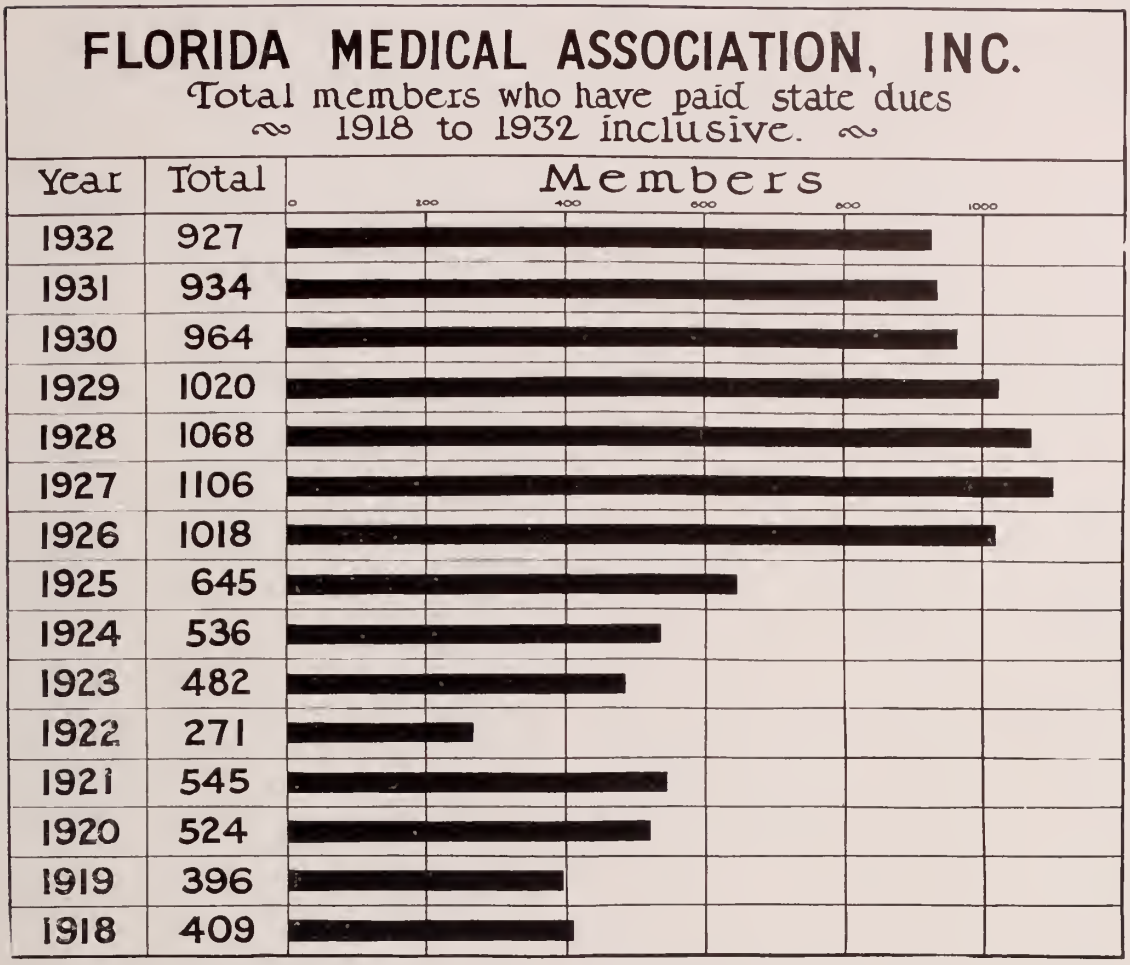
Each year brings additional work to our regular routine office activities. The office duties during preceding years were quite heavy, but during the past year, the work increased materially. It is quite difficult to draw a word picture of the manifold details necessary to bring the results that have been attained thus far. During the past year, 6,031 first-class letters were typed and mailed and 332 packages handled, in addition to thousands of circular letters mimeographed. Seven copies of each radio broadcast were typed and newspaper releases mimeographed. A roster for each county society was typed and brought up to date for each of the various secretaries.

All material for the Journal is edited before being turned over to the printer and carefully proofread after the typesetting has been completed. Galley proofs of all original articles were submitted to essayists for approval before publishing the Journal.

All correspondence is promptly answered and this is no small task as may be noted by the first-class mail designated above. The fact that this year's report shows only seven paid members less than for the previous year speaks for the efficiency of your central office as well as for the activities of the officers of the component societies.

While the income from advertising is not as great as for the previous year, the showing made represents a much greater volume of effort and work because of economic conditions. Aid given to the entertaining society also requires considerable time. The expenses budgeted for this year's entertainment of the State Association have been provided by the sale of exhibit spaces and other means of revenue. It has often been asked why we do not have a registration fee at our annual conventions, and this is easily answered. Expenses in connection with the annual convention are provided through the activities of your office force, lightening the expense of the members and delegates who attend. As a direct result of this, the Orange County Medical Society reduced their local dues three dollars per member during the past year. A portion of this society's local dues in previous years had been deposited in a savings account in anticipation of expense money necessary when it became their turn to entertain the State Association. However, after having recently entertained the State Association without additional cost to the members of their society, they found this reserve unnecessary.

Every means of economy has been resorted to in the operation of the office. All material, stationery and equipment have been purchased at the very lowest figure possible. Competitive bids have been taken before making any purchases



and in most instances wholesale prices have been obtained.

Your officers and committeemen are using the office service more each year. This not only keeps on file in a central office copies of letters and records but also lightens the expense and conserves the time of busy doctors.

The President and Secretary of each component society were warned against a swindler who gave his name as M. R. James and who was reported to have swindled a number of physicians in Georgia while posing as a representative of the Washington Instrument Company of Washington, D. C. Reports of impostors should be dispatched as quickly as possible to your Jacksonville office in order that the entire membership of our Association may be warned.

Correspondence was carried on for the Legislative Committee with the various candidates for state offices, thereby securing letters from the candidates both for public offices and the Legislature, pledging their aid and support of the interests of organized medicine. Through this correspondence was also secured the names of the family physicians of the different individuals who were elected and the list of names has been preserved for the use of the Legislative Committee in bringing to the attention of the members of the Legislature facts concerning questions on bills affecting the medical profession in the Legislature. Journals from the Senate and House of Representatives are carefully read each day and all bills introduced affecting the doctors are immediately referred to our Legislative Committee.

Since the engaging of Marks, Marks, Holt, Gray and Yates as legal advisors, our office has acted as a clearing house, referring letters pertaining to legal questions to this firm, forwarding the legal opinions to the correspondent and filing a carbon copy for reference. In the future, it is hoped that the members of our Association will to a larger extent avail themselves of this opportunity to secure legal advice when the occasion arises.

We have endeavored to operate the office as efficiently and economically as possible and while the members of the Association are busily engaged in their professional duties, your office

force has been on the job in an effort to look after your interests.

FORD, BOYD & COLLEY
CERTIFIED PUBLIC ACCOUNTANTS

Jacksonville, Fla.,
April 26, 1933.

Dr. Shaler A. Richardson,
Treasurer, Florida Medical Association,
Jacksonville, Florida.

Dear Sir: This is to certify that we have examined the attached statements of Cash Receipts and Cash Disbursements for the period from April 16, 1932, through April 17, 1933. These statements have been prepared by Dr. S. G. Thompson, Business Manager of the Florida Medical Association and the Florida Medical Journal, and correctly reflect the total amounts received and disbursed as shown by the books.

In accordance with your instructions we have checked the total of the collections shown by the statements with the corresponding total shown by the books, and found them to be in agreement.

Cancelled checks were examined and compared with the entries in the cash disbursement book; the cash book was added and all postings checked to the general ledger; and the general ledger was added and a Trial Balance taken off as of April 17, 1933.

Bank accounts were reconciled with the bank statements.

As we do not have access to the records of the various County Societies for the purpose of checking the remittances for dues, attention is directed to exhibits D and F which show the amount received from each County Society during the year and dues cancelled, respectively. The inspection of these exhibits by the officers of the respective societies will enable them to verify the correctness of the remittances and cancellations shown.

Income from journal advertising was verified substantially by an examination of the contracts with advertisers.

Ten (10) U. S. Treasury bonds, par value $1,000.00 each (interest rate 3⅜%) were inspected by us. These bonds represent an investment of the Association; interest collected on them during the year amounted to $337.50.

We wish to state that the books and records of the Association have been well and neatly kept.

Yours very truly,

FBC:S FORD, BOYD & COLLEY.

CONSOLIDATED CASH STATEMENT
April 16, 1932, through April 17, 1933.

Receipts

Cash in Bank, April 15, 1932		$11,100.44
Dues Collected (Exhibit "D")	$ 8,220.00	
Earnings from Advertising (Exhibit "E")	2,240.60	
Subscription and Miscellaneous Sale of Journal	16.92	
Bonus from Cooperative Medical Adv. Bureau	150.24	
Interest on Savings and Investment	544.24	
Earnings—Technical Exhibit (Exhibit "C")	442.50	11,614.50
Total Cash to be Accounted for		$22,714.94

Disbursements

General Fund Expenses (Exhibit "A")	$ 4,746.18	
Journal Expenses (Exhibit "B")	5,626.60	
Technical Exhibit Expenses (Exhibit "C") $113.67		
To Entertaining Societies 235.50	349.17	
Furniture and Fixtures	40.70	
Library	9.25	
Federal Tax	7.20	10,779.10
Balance in Bank, April 17, 1933		$11,935.84

EXHIBIT "A"

CASH STATEMENT—GENERAL FUND
April 16, 1932, through April 17, 1933.

Receipts

Cash as per last audit		$16,352.95
Back Dues Collected (Exhibit "D")	$2,580.00	
Current Dues Collected (Exhibit "D")	5,640.00	8,220.00
Interest on Savings and Investment		544.24
Total Cash to be Accounted for		$25,117.19

Disbursements

Postage and Supplies	$ 314.63		
Telephone and Telegraph	121.98		
Salaries	3,273.28		
Secretary-Treasurer Salary	500.00		
Convention Expense	159.19		
Bond of Treasurer	18.75		
Office Rent	180.00		
Legal Counsel	91.66		
Editing Releases from Newspaper Angle	19.00		
Photostats of Charts for President Holden	7.60		
Custody of Bonds	10.00		
Traveling Expenses	42.84		
Incidental Expense	7.25	$4,746.18	
Federal Tax		7.20	
Furniture and Fixtures		40.70	
Library		9.25	
To Journal Fund ($3.00 per member paid, 1931, 1932 and 1933 collections)		2,466.00	7,269.33
Cash Balance			$17,847.86

EXHIBIT "B"

CASH STATEMENT—JOURNAL FUND
April 16, 1932, through April 17, 1933

Receipts

As per last audit (overdraft)		—$ 5,661.13
Earnings from Advertising (Exhibit "E")	$2,240.60	
Subscription and Miscellaneous Sale of Journal	16.92	
Bonus from Cooperative Med. Adv. Bureau	150.24	
From General Fund	2,466.00	4,873.76
To be Accounted for		—$ 787.37

Disbursements

Postage and Supplies	$ 205.20	
Telephone and Telegraph	69.06	
Salaries	1,600.76	
Editor's Salary	500.00	
Printing of Journal and Electrotypes	3,155.58	
Bond of Treasurer	18.75	
Drayage	16.25	
Press Clipping Service	40.50	
Incidental Expense	20.50	5,626.60
Balance—Overdraft		—$ 6,413.97
Plus Balance General Fund		17,847.86
Plus Balance Exhibit Fund		501.95
Net Cash Balance in Bank		$11,935.84

EXHIBIT "D"
DUES COLLECTED APRIL 16, 1932, THROUGH APRIL 17, 1933.

Name of Society	Total Members	No. Paid Members	No. in Arrears	1933 Dues Collected	Back Dues Collected
Alachua	22	12	10	$ 110.00	$ 40.00
Bay	6	1	5		
Brevard	10	5	5	40.00	20.00
Broward	16	16	0	150.00	20.00
Columbia	7	7	0	60.00	
Dade	172	115	57	1,140.00	770.00
DeSoto-Hardee-Highlands	17	7	10	60.00	40.00
Duval	139	65	74	640.00	450.00
Escambia	40	21	19	200.00	190.00
Hillsboro	82	54	28	530.00	380.00
Individuals	1	0	1		10.00
Jackson	9	5	4	40.00	10.00
Lake	17	14	3	130.00	
Lee	8	7	1	60.00	10.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	28	13	15	120.00	30.00
Madison	2	0	2		
Manatee	13	6	7	50.00	
Marion	13	8	5	70.00	30.00
Monroe	4	4	0	30.00	10.00
Orange	45	31	14	300.00	100.00
Palm Beach	37	28	9	270.00	20.00
Pasco-Hernando-Citrus	15	8	7	70.00	40.00
Pinellas	74	53	21	520.00	160.00
Polk	52	36	16	350.00	40.00
Putnam	6	2	4	10.00	10.00
St. Johns	11	10	1	90.00	
St. Lucie-Okeechobee-Indian River-Martin	13	13	0	120.00	10.00
Sarasota	12	11	1	100.00	10.00
Seminole	11	11	0	100.00	
Sumter	3	3	0	30.00	
Taylor	7	4	3	30.00	
Volusia	33	17	16	160.00	180.00
Walton-Okaloosa	7	7	0	60.00	
	932	594	338	$5,640.00	$2,580.00

2,580.00 Back dues collected

$8,220.00 Total dues collected

EXHIBIT "C"
CASH STATEMENT—EXHIBIT FUND
April 16, 1932, through April 17, 1933

Receipts

Cash as per last audit	$ 408.62	
Earnings from Technical Exhibits	442.50	
Total Cash to be Accounted for		$ 851.12

Disbursements

Postage and Supplies	$ 4.00	
Telephone and Telegraph	1.42	
Salaries	1.25	
Drawing, Printing, Sign Painting, etc.	34.05	
Construction of Booths	50.60	
Incidental Expense	22.35	$113.67
To Entertaining Society (Sarasota)		153.00
To Entertaining Society (Broward)		82.50
		349.17
Cash Balance		$ 501.95

EXHIBIT "E"
EARNINGS FROM ADVERTISING
April 16, 1932, through April 17, 1933

May, 1932	$ 163.86
June	234.89
July	205.64
August	214.85
September	124.60
October	209.85
November	127.40
December	196.46
January, 1933	153.32
February	195.00
March	101.59
April	313.14
Total	$2,240.60

EXHIBIT "F"
NAMES OF MEMBERS DROPPED BY REASON OF REMOVAL, NON-PAYMENT OF DUES, ETC.
April 16, 1932, through April 17, 1933.

	Dues Not Paid 1932	1933
ALACHUA COUNTY MEDICAL SOCIETY:		
Goode, J. A., Alachua	$10.00	$....
Maines, John E., Sr., Lake Butler	10.00	
Raborn, John D., Trenton	10.00	
BAY COUNTY MEDICAL SOCIETY:		
Bartee, L. H., Lynn Haven	10.00	
Fraser, Donald C., Panama City	10.00	
Whitfield, J. M., Panama City	10.00	
BROWARD COUNTY MEDICAL SOCIETY:		
Hartley, James M., Hollywood		10.00
Hodges, J. W., Miami (to Dade County)		10.00
Winsor, Sanford A., Pompano	10.00	10.00
COLUMBIA COUNTY MEDICAL SOCIETY:		
Hoffman, Clifford W., Lake City	10.00	
DADE COUNTY MEDICAL SOCIETY:		
McKenzie, J. S., Miami	10.00	
Norton, Richard C., Miami Springs	10.00	
DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY:		
Bevis, Henry P., Arcadia	10.00*	
Martin, I. E., Ft. Ogden	10.00	
Touchton, W. C., Avon Park	10.00	
DUVAL COUNTY MEDICAL SOCIETY:		
Brown, Alan DeWitt, Jacksonville	10.00*	
Copeland, S. M., Jacksonville	10.00	
Goethe, James E. (deceased), Jack'ville	10.00	
Gorman, John M., Jacksonville	10.00	
Herlong, M. B., Jacksonville	10.00	
Ives, H. A., Jacksonville	10.00	
Key, Foster P., Green Cove Springs	10.00	
Morgan, Thos. E., Jacksonville	10.00*	
Proctor, H. L., Jacksonville	10.00	
Rollins, C. D., Jacksonville	10.00	

	Dues Not Paid 1932	1933
Sanderson, Raymond, Jacksonville	10.00	
Stull, Wm. P., Jacksonville	10.00	
Wilson, B. C., Clarkson, Ky.	10.00	
HILLSBORO COUNTY MEDICAL SOCIETY:		
Baldwin, R. E., Tampa		10.00
Christian, George R., Tampa		10.00
Crum, James W., Tampa	10.00	10.00
Foster, John C., Tampa	10.00	
Golden, H. M., Chicago, Ill.		10.00
Hubbard, Roscoe C., Tampa	10.00	10.00
Jobson, A. M. C., Tampa	10.00	10.00
Lassman, George A., New York, N. Y.		10.00
McMurray, Henry E. (deceased), Tampa	10.00	
Pate, Julien C., Tampa	10.00	10.00
Scuderi, S. A., Tampa		10.00
INDIVIDUALS:		
Laffitte, L. Sydnor, New York, N. Y.	10.00	
Pease, Charles W., Orlando	10.00	
Stebbins, A. L., Punta Gorda	10.00	
Strickland, Henry M., Live Oak	10.00	
Webb, Walter D., Boca Grande	10.00	
JACKSON COUNTY MEDICAL SOCIETY:		
Marshburn, E. R., Marianna	10.00	
Miller, R. L., Graceville	10.00	
Price, C. J., Alford	10.00	
LEE COUNTY MEDICAL SOCIETY:		
Whisnant, B., Ft. Myers	10.00	
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY:		
Beggs, J. M., Chattahoochee	10.00	
Gainey, J. G., Quincy	10.00	
Gardner, O. W., Greensboro	10.00	
Walker, W. H., Lamont	10.00	
MADISON COUNTY MEDICAL SOCIETY:		
King, L. P., Greenville	10.00	
MARION COUNTY MEDICAL SOCIETY:		
Baskin, J. G., Dunnellon	10.00	
Slaughter, T. K., Wildwood	10.00	
ORANGE COUNTY MEDICAL SOCIETY:		
Westcott, Wm. E., Orlando	10.00	
PALM BEACH COUNTY MEDICAL SOCIETY:		
Moorefield, J. L., Deerfield	10.00	
Henry, G. F., W. Palm Beach	10.00	10.00
Schiffli, O. F., Highlands, N. C.	10.00	
Webb, Roy, Palm Beach	10.00	10.00
Whitman Frank S., W. Palm Beach	10.00	10.00
PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY:		
Hancock, Wm. S., Jr., New Port Richey	10.00	
PINELLAS COUNTY MEDICAL SOCIETY:		
Bowen, J. T., Clearwater	10.00	10.00
Ruff, J. T., Clearwater	10.00	
POLK COUNTY MEDICAL SOCIETY:		
Biddle, Percy D., New Haven, Conn.	10.00	
Causey, Thos. W., Lakeland	10.00	
Deal, C. C., Auburndale	10.00	
Gilbert, R. E., Winter Haven	10.00	
Lowry, J. B., Nichols	10.00	
Tomlinson, J. P., Sr., Lake Wales	10.00	
Tomlinson, J. P., Jr., Lake Wales	10.00	
Vassar, T. D., Lakeland	10.00	
PUTNAM COUNTY MEDICAL SOCIETY:		
Zeagler, G. M., Palatka	10.00	10.00
VOLUSIA COUNTY MEDICAL SOCIETY:		
Carter, Emory A., Longwood	10.00	10.00
Chowning, W. C., New Smyrna	10.00	10.00
	$680.00	$190.00
Dues of Secretaries		300.00
	$680.00	$490.00
		680.00
Total		$1,170.00

*Reinstated.

ASSETS AND LIABILITIES
April 17, 1933

Assets

Cash in Bank	$4,216.39
General Fund—Accounts Receivable	3,410.00
Journal Fund—Accounts Receivable	55.07
Furniture and Fixtures (less depreciation)	209.27
Library	112.80
Stationery Inventory	81.67
Savings—Barnett National Bank	7,719.45
Investment (Treasury Bonds)	10,178.13
	$25,982.78

Liabilities

Capital Account	$25,982.78

On motion by Dr. L. M. Anderson, duly seconded and carried, the above report was adopted as read.

The report of the Executive Committee was read by Dr. O. O. Feaster, Chairman, of St. Petersburg, as follows:

THE REPORT OF THE EXECUTIVE COMMITTEE

The Executive Committee was appointed and held its first meeting in Sarasota immediately after the close of the Association's last convention. A budget was adopted, the present Business Manager was reappointed and office arrangements for the conduct of the organization's business were continued since several months' use had proved their efficiency and economy.

Before the details of the State Association's plan for rendering financial assistance to County Societies in the prosecution of irregulars had been published in the Journal, the Lee County Society acquired obligations totaling $100.00 in the prosecution and conviction of one Armstrong in the lower courts. The financing not having been handled in accordance with the provisions laid down, this committee was unable to appropriate the fifty dollars which should have been supplied. However, we recommend that the Association reimburse the Lee County Medical Society to the extent of fifty dollars.

The Committee finds that when a convicted malpractice violator appeals his case to a higher court, there are no funds available to the State Board of Medical Examiners, or any other agency, to protect the interests of organized medicine. It is, therefore, recommended that the House of Delegates authorize the Executive Committee to expend, upon advice of the Association's legal counsel, not to exceed $200.00 in any one case, nor $600.00 in any one year for a proper representation in such appealed cases.

The Committee, after considerable investigation, endorsed on behalf of the Florida Medical Association, a week of post-graduate work to be

held this summer at the University of Florida. The course has been excellently planned by the Committee: Dr. T. Z. Cason of Jacksonville, Dr. G. C. Tillman of Gainesville and Dr. T. H. Bates of Lake City. The teachers are to be paid actual expenses only and indications are that the registration fees will be ample to cover the necessary outlay. However, it is believed advisable for the Association to underwrite the finances of the post-graduate course, to an extent not exceeding five hundred dollars, to avoid embarrassment in the event any deficiency occurs and action to this effect is requested of the House of Delegates.

We recommend that the incoming President appoint an Economics Committee to investigate and gather information on the many economic phases of the practice of medicine, particularly with regard to free clinics, school examinations, and other economic problems; that this committee encourage the appointment of similar committees in the county societies and they cooperate with a view to obtaining the results described as desirable in the President's address; that the committee report its findings at the 1934 meeting, so that the State Association may adopt some uniform program.

Some months ago, the field representative of the American Society for the Control of Cancer contacted this committee and offered their "Five-Year Plan", which has been adopted by several states. While this program is altogether too elaborate for us at this time, we believe that the benefits to be derived and the forestalling of lay philanthropic organization activities along this line render the limited acceptance of the plan advisable. Therefore, it is recommended that the incoming President appoint a committee of five, whose respective terms shall run for five, four, three, two and one years, with the vacancy filled each year, to handle this matter.

Respectfully submitted,

THE EXECUTIVE COMMITTEE,
O. O. FEASTER, Chairman;
LEIGH F. ROBINSON,
WM. H. SPIERS,
GERRY R. HOLDEN,
SHALER RICHARDSON.

It was moved, seconded and carried that the report of the Executive Committee be adopted as read.

Dr. W. M. Rowlett of Tampa, Chairman of the Committee on Legislation and Public Policy, read the following report, which was unanimously adopted:

REPORT OF COMMITTEE ON LEGISLATION AND PUBLIC POLICY

Your Committee on Legislation and Public Policy has had rather an active year. Before the primary every candidate for state office was contacted with regard to his attitude toward organized medicine. We were successful in the election of four physicians to the state senate. These physicians have been appointed on the Public Health Committee of the Senate, which places on that important committee four physicians and one layman.

The committee has recently had two conferences in Tallahassee, where it went over with the Public Health Committees of the legislature the proposed acts pertaining to the healing arts that are now before that body. A few of the proposed acts are, to-wit:

H. 18—Repeals the optometry law.
H. 28—Permits other than licensed optometrist to sell glasses.
H. 45—Creates a state Chiropractic supervisor.
S. 107—Defines and regulates the practice of beauty culture.
S. 115—Regulates the practice of Chiropody.
H. 124—Abolishes the office of supervisor of physical education.
H. 135—Permits the levy of one-half mill special tax on all assessable property for the maintenance of the state board of health.
H. 156—Repeals the present barbering law and places inspection under the state board of health.
S. 203—Establishes a state board of credentials to pass upon qualifications of practitioners of medicine, osteopathy, chiropractic, naturopathy and any form of healing.
S. 212—Relating to the practice of midwifery, requiring all midwives to obtain a license before engaging in the practice of same.
S. 243—Provides for a levy of a 2% tax on physicians' incomes.
H. 397—Permits an unlimited use of alcoholic liquors for medical and sacramental purposes.

There are rumors that several new cults will endeavor to gain legal recognition at this session of the legislature. Those that we have thus far heard of have also endeavored to gain recognition

in other states, namely, neuropaths in Pennsylvania, masseurologist in California, naprapathy and sanatology in Illinois, physiotherapy in New York, and the X-ray technicians who are perfecting an organization.

Your committee will do all that is within its power to see that the proposed laws that this association endorse, are enacted and those that you believe are detrimental to the good of the public, are defeated. To accomplish your wishes, we must have the active, individual support of every society and its members in the state. We were very disappointed in not having a one hundred percent response to our recent call upon the county societies to interview your local legislators, on our proposed Credentials Act, before they left their homes for Tallahassee. To those few who overlooked this important request, we ask that you be charitable enough not to criticise your committee, or the association, in the event of insufficient laws whereby the state could eliminate the bogus healer, and the atrocious "mill" that creates him. We feel that in the proposed Credentials Act our people would have proper protection.

We find in the annual report of the State Board of Medical Examiners, that during the past year there were sixty-five physicians licensed, eight applicants failed on their examinations. Twenty-six applications were turned down, six refused on the grounds of being graduates of low grade medical colleges, four having previously been convicted of a crime involving moral turpitude, sixteen being political refugees from foreign countries.

As to public policies, every physician in active practice realizes that these are turbulent days for organized medicine. There are many new problems to be faced and worked out. The public has become dollar and health conscious. While the physician is striving to recoup the small fortune he has spent in preparation of his practice, the layman is shopping for health bargains.

The situation is true not only in medicine, but also in the other professions and vocations: law, engineering, financial institutions, etc. The problem confronting the public is that of securing proper distribution of medical service at what the layman terms a reasonable cost. It is thought by some of the leaders in the profession that over-specialization has been injurious to our cause. Statistics show that not more than 15% of patients require the service of specialists. Yet 40% of recent medical graduates leave college without special preparation, to take up a limited work. Many of the states realizing the seriousness of this condition, are advocating laws requiring the young specialist to take additional training and special examinations for license. The present agitation over health matters has a great political significance.

Therefore to be able to cope with the situation intelligently, the physician must pay more attention to public questions. We feel that there are a few outstanding traditions that we should strive to maintain, and in order to stimulate wholesome competition, which is the foundation of success, we should encourage individual practice by permitting the patient the privilege of selecting the physician of his choice.

Insurance or corporate practice, in addition to interfering with the freedom of the patients, denying them their rights to choose their physician, also robs the physician of his individuality by certain restrictions that are beyond his control.

We believe that public hospitals with public treatment rooms unless limited strictly to indigent patients are operating contrary to the principles and ethics of the profession. They are unfair competitors, taking money from both pockets of the physician, the first for taxes to maintain this competition, and the second, robbing him of a fee that he would otherwise have had.

We believe that contract practice, unless limited to patients of the lowest income class and sanctioned by the county society, is contrary to the underlying principles of our profession. It destroys the morale, which is the balance wheel of the practice of medicine, by competitive bargaining. Then again the corporation is the one benefiting financially by the physician's knowledge and efforts instead of the physician. Medical service will never be successfully sold as a commodity, and mass sales are the instrument of the fakes and quacks.

We commend that this association endorse the stand of the Federation of State Boards of Medical Examiners, in their efforts to control the American medical student who has matriculated in the European medical schools, many whose curriculum is below our standard. At the present time there are 1,500 American students in these European medical schools.

There being a continuous increase in the number of people who annually come to this state to regain their health, and realizing the growing

abuses resulting from the improper use of the title "specialist" we also recommend that the Florida Medical Association devise some plan whereby it may issue certificates of qualification to those worthy of this title.

Respectfully submitted,
W. M. Rowlett, Chairman;
J. C. Davis,
S. E. Driskell,
H. E. Palmer,
C. E. Tumlin.

The report of the committee on Hospital and Medical Education was read by Dr. Walter A. Weed, Chairman, of Lakeland, as follows:

REPORT OF THE HOSPITAL AND MEDICAL EDUCATION COMMITTEE

Almost every one can attest the fact that unusual achievements were not to be expected during the past year. The continued and increasing financial depression with the resultant recessions and retrenchments in almost every line of human endeavor has not been without its effect on the hospitals of our country. However, it is the opinion of your committee that the hospitals of this state deserve much commendation for maintaining their standards in the face of an ever-increasing financial handicap.

In 1932 there were 23 fully approved, and 9 conditionally approved, hospitals in the state, while at the present time there are 27 fully approved, and only 4 conditionally approved. That, of course, leaves something like 45 institutions that remain unclassified—that is, not on the approved list.

The fully approved, and conditionally approved, hospitals of the state represent a total bed capacity of 3,251, while those not on the approved list have a total bed capacity of 4,081. In this latter group there are included only two hospitals of more than 50 bed capacity, the remainder being either small public, or private, hospitals, many of which are either too small, or so located, as to make it impossible for them to meet the minimum requirements. Mention might be made that nervous and mental hospitals, maternity hospitals, tuberculosis sanatoriums, etc., have not been included in the above figures. Also, in this connection, it might be said that there are several small hospitals that fail only in a minor degree to meet the minimum requirements, and whose management deserve much credit for their continued efforts to attain the highest possible standards. These hospitals merit some kind of recognition, but, as yet, there is no provision for their classification, and, besides, your committee would hesitate to list them for fear of omitting other equally deserving institutions, the status of which we are unaware because of the vastness of the state, and the impossibility of making a personal inspection of every institution.

Your committee has sent letters to every unapproved hospital in the state setting forth the "minimum requirements", and offering to give any assistance possible in their effort to attain the minimum standard. The response, though disappointing, seems to have been as good, or better, than in previous years, and, with the advent of better financial conditions, we believe there are several small hospitals on the unapproved list that will soon meet the requirements of the minimum standard.

If it comes within the province of the duties of this committee, we are of the opinion that the greatest assistance that the committee could render, not only the smaller hospitals but the larger ones as well, would be to work out a joint publicity program with the Public Relations Committee of the Florida State Medical Association, Inc., and the Public Relations Committee of the Florida Hospital Association, similar to the one-year program suggested at the last meeting of the American Hospital Association. It is our opinion that much effective and constructive work can be done along this line, which will prove beneficial both to our physicians and hospitals, and, eventually, will be of material assistance to some of the smaller hospitals in attaining the minimum standard. We respectfully request that this matter be referred to the Executive Committee for its consideration.

Respectfuliy submitted,
The Medical Education and Hospital Committee,
Walter A. Weed, Chairman;
R. O. Lyell,
Harry F. Watt.

Motion by Dr. W. M. Shaw of Jacksonville that the above report be accepted. Seconded and carried.

Due to the absence of Dr. Ralph N. Greene, Chairman, of Jacksonville, the Council's Report was not given.

In the absence of Dr. Henry C. Dozier, Chairman, Ocala, the following report of the Committee on Necrology was read by the Association's Secretary, which was adopted following a motion by Dr. L. M. Anderson:

REPORT OF COMMITTEE ON NECROLOGY

During the past year, our Association lost, by death, the members whose names are listed below:

D. M. Adams, Panama City
Robert E. Baldwin, Tampa
Wilmer C. Box, Graceville
George A. Christian, Tampa
Carl H. Harrison, Cottondale
Norman M. Heggie, Jacksonville
John S. Helms, Tampa
T. H. Hudgens, Sneads
Clarence E. Hutchinson, Ocean Springs, Miss. (formerly of Pensacola.)
J. M. Irwin, St. Augustine
William B. Jordan, Ocala
Henry E. McMurray, Tampa
Daniel L. McSwain, Arcadia
J. Robert Simpson, Miami
Ralph E. Smith, Jacksonville
George S. Stone, Ft. Myers
Milton Walton, Hastings

Where possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they practiced.

May we, at this time, stand in a moment of silence, in reverence and respect to the memory of our departed colleagues.

HENRY C. DOZIER, Chairman;
NELSON M. BLACK,
GEORGE M. DAWSON,
HARRY C. GALEY,
W. J. JOHNSTON,
R. H. KNOWLTON,
G. W. POTTER,
JOHN S. TURBERVILLE.

The following report was read by Dr. T. Z. Cason of Jacksonville, as Chairman of the Committee on Medical Post-Graduate Course:

REPORT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE

The first meeting was held at the University of Florida Infirmary, Gainesville, January 28th, with full attendance of the committee. The University was represented by Dean Riley of the General Extension Division and Mr. Mitchell, Secretary. The general plan of the course was outlined and agreed upon by the committee and the representatives of the University, and the time set for June 19th-24th.

Numerous subsequent meetings have been held, at which times in addition to the committee, Dr. Gerry Holden, President of the Florida Medical Association, and Dr. Shaler Richardson, Secretary, were present.

The committee is glad to report that the program is now complete and the Bulletin is being distributed at this meeting. We are also pleased to report that in no instance has any doctor declined the assignment. The personnel of the institute is comparable to that instructing in similar courses anywhere in the country. Also, they will take up all subjects from the standpoint of the general practitioner rather than from that of the specialist. The men from out of the state are delivering these lectures without remuneration except their actual traveling and living expenses.

This committee is offering these arrangements to the state association for its approval. We feel that great benefit will result from the course and trust that the House of Delegates will see fit to authorize the presentation of this course. Tickets of admission for this course have been arranged at the rate of $5.00 for each man for the entire course. While it is hoped that the receipts will be sufficient to defray all expenses there is, of course, a possibility that they will not. If, therefore, the House of Delegates sees fit to authorize the state association to take care of any deficit which might occur, the success of the course will be much more certain. We feel that at the most such a deficit would not be more than a few hundred dollars and it is quite possible there would be no deficit whatever.

Respectfully submitted,
T. Z. CASON, Chairman.
T. H. BATES,
G. C. TILLMAN.

Motion by Dr. L. M. Anderson, that the above report be adopted as read, and that the recommendations contained therein be referred to the House of Delegates. Seconded and carried.

Dr. Leland Carlton, Chairman, Tampa, read the following report of the committee appointed by the President to confer with a committee from the State Board of Health:

JOINT COMMITTEE REPORT— FLORIDA MEDICAL ASSOCIATION AND STATE BOARD OF HEALTH

Your committee in conjunction with a committee from the State Board of Health, has attempted through the secretaries of each component society of the State Medical Association, to ascertain if there be any friction between the State Board of

Health and the Medical profession in that area. If any friction be present, we have asked recommendations from the County Societies, as to alleviating those difficulties. The response to our requests has been most gratifying, and all criticisms have been of a constructive nature.

From the letters and a study of conditions in general, your committee begs leave to make the following recommendations:

1st. That the State Medical Association go on record as opposing free medical service for public clinics sponsored by Lay organizations, unless those patients so examined have been proven to be indigent.

2nd. That there be a closer relationship and better understanding between the State Board of Health and the local Medical Societies.

3rd. That the local Societies be given opportunity to do all necessary preventive medicine where practicable and if not done by them, then the State Board of Health may feel at liberty to do so.

4th. That the State Board of Health physicians should act as consultants with members of local medical societies when called upon in cases of infections and contagions and in all matters pertaining to public health and sanitation.

5th. That the State Board of Health physicians act as advisory counsel to local physicians and devote more time to public education rather than private administery to the needs of the sick.

6th. That our organization go on record requesting the state to appropriate funds sufficient for immunization against diseases such as diphtheria, smallpox, tetanus, gas bacillus infection, hydrophobia, typhoid, etc., the distribution of same to be through the State Board of Health.

FROM FLORIDA MEDICAL ASSOCIATION

LELAND F. CARLTON, *Chairman;*
H. C. DOZIER,
J. M. IRWIN.

FROM THE STATE BOARD OF HEALTH

H. MASON SMITH,
HENRY HANSON.

On motion duly made, seconded and carried, the above report was adopted, and the committee discharged.

A resolution was read by Dr. H. E. Palmer of Tallahassee, recommending that the Eighteenth Amendment to the Federal Constitution be submitted to a national referendum.

Dr. C. D. Christ moved that the resolution as read by Dr. Henry Palmer be referred to the House of Delegates. Seconded and carried.

Motion to adjourn by Dr. L. M. Anderson; seconded and carried.

FIRST SCIENTIFIC ASSEMBLY

Dr. L. M. Anderson, Lake City, Chairman of the Committee on Scientific Work, took the Chair at 3:00 p. m., May 2nd. He expressed his appreciation of the efficient cooperation of Drs. Leland F. Carlton and Edward Jelks in the preparation of the program on scientific work.

The following papers were read and discussed:

"Poisonous Effect of the Nuts of the Tung Oil Tree if Eaten by Man," Henry E. Palmer, Tallahassee.

"Treatment of Hemophilia with Ovarian Extract," Joseph S. Spoto, Tampa.

"Lymphopathia Venerea," Alan Brown, Jacksonville.

FIRST MEETING OF THE HOUSE OF DELEGATES

The meeting of the House of Delegates was called to order at 5:00 p. m. Tuesday, May 2nd, by Dr. Gerry R. Holden, President.

The roll call by the Secretary showed the following delegates, alternates or substitutes present:

DELEGATES

ALACHUA COUNTY MEDICAL SOCIETY—
George C. Tillman
BREVARD COUNTY MEDICAL SOCIETY—
Walter C. Page
BROWARD COUNTY MEDICAL SOCIETY—
Elliott M. Hendricks
COLUMBIA COUNTY MEDICAL SOCIETY—
L. M. Anderson
DADE COUNTY MEDICAL SOCIETY—
Roy J. Holmes
Homer L. Pearson
J. R. Pearson
C. E. Tumlin
F. A. Vogt
M. C. Wilson
R. C. Woodard
DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY—
Leldon W. Martin
DUVAL COUNTY MEDICAL SOCIETY—
Alan Brown
S. E. Driskell
George Richardson
W. M. Shaw
Frederick J. Waas
ESCAMBIA COUNTY MEDICAL SOCIETY—
H. L. Bryans
HILLSBORO COUNTY MEDICAL SOCIETY—
J. R. Boling
Leland F. Carlton
J. C. Vinson
JACKSON COUNTY MEDICAL SOCIETY—
D. A. McKinnon
LAKE COUNTY MEDICAL SOCIETY—
Leroy H. Oetjen
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY—
Henry E. Palmer
MANATEE COUNTY MEDICAL SOCIETY—
M. T. McDuffee
MARION COUNTY MEDICAL SOCIETY—
J. L. Strange
MONROE COUNTY MEDICAL SOCIETY—
George R. Plummer

Orange County Medical Society—
J. R. Chappell
H. A. Day
Palm Beach County Medical Society—
George M. Dawson
Frederick K. Herpel
Pasco-Hernando-Citrus County Medical Society—
T. F. Jackson
Pinellas County Medical Society—
William M. Davis
O. O. Feaster
Alvin L. Mills
Polk County Medical Society—
R. L. Cline
Herman Watson
Putnam County Medical Society—
A. E. Drexel
St. Johns County Medical Society—
George W. Potter
St. Lucie-Okeechobee-Indian River-Martin County Medical Society—
J. A. Newnham
Sarasota County Medical Society—
Jack Halton
Sumter County Medical Society—
S. C. Wood
Volusia County Medical Society—
J. Ralston Wells

Bay, Lee, Madison, Seminole, Taylor and Walton-Okaloosa County Medical Societies were not represented.

Upon motion made, seconded and carried, the minutes of last year's meeting were adopted as published in the May, 1932, Journal.

President Holden stated that the next order of business was the consideration of the proposed changes in the constitution and by-laws.

Motion by Dr. E. M. Hendricks that the revised constitution and by-laws be adopted as published in the January, 1933, Journal. Carried by unanimous vote.

The President then called for the nomination of delegates to the American Medical Association —one regular delegate and one alternate to serve a two-year term.

Dr. Herman Watson nominated Dr. Bundy Allen of Tampa, as a regular delegate. Seconded by Dr. W. M. Shaw.

Dr. H. E. Palmer nominated Dr. Gerry R. Holden of Jacksonville, as a regular delegate. Seconded by Dr. F. J. Waas.

A request by Dr. Holden that his nomination be withdrawn was refused.

Upon motion made, seconded and carried, the nominations were closed.

Drs. Waas, Driskell, Page and Tillman were appointed tellers.

Ballot vote resulted in the election of Dr. Gerry R. Holden.

Drs. W. C. Page, Homer Pearson, and Bundy Allen were nominated for alternate delegate.

Upon motion by Dr. F. J. Waas, duly seconded, the nominations were closed.

Dr. Bundy Allen was elected.

The next order of business was the selection of a meeting place for 1934.

Dr. F. J. Waas extended an invitation on behalf of the Duval County Medical Society for the 1934 convention to be held in Jacksonville. Seconded by Dr. L. M. Anderson.

Dr. J. L. Strange, representing the Marion County Medical Society, invited the Association to meet in Ocala. Seconded by Dr. E. G. Peek.

Dr. Jack Halton moved that the nominations be closed. Seconded and carried.

On standing vote Jacksonville was selected as the 1934 meeting place.

Dr. Herman Watson offered the following resolution:

Any member of the Florida Medical Association who has been an active member of the Association for 35 years shall be made a life member of the Association and exempt from all dues.

President Holden announced that this resolution, if adopted, would require a constitutional amendment.

It was moved and seconded that the above resolution take the regular course.

The following resolution was read by Dr. E. M. Hendricks:

Whereas, the Medical Officers of the U. S. P. H. S., and the Army and Navy Medical Departments are physicians of high standing with recognized qualifications and ability, and their service connection makes it impracticable for them to join the Florida Medical Association in the regular manner; and

Whereas, this Association will receive benefit from their attendance at annual meetings; be it therefore

Resolved, That this Association in regular session extends to the medical officers of the United States Public Health Service and Army and Navy an invitation to attend our annual sessions, and that the privileges of the floor be extended to them.

Dr. H. E. Palmer moved that this resolution be amended to include the Rockefeller Foundation as represented in this State. Amendment accepted.

Dr. Jack Halton offered a motion that the above resolution be further amended to include retired Army and Navy Medical Officers. Amendment accepted.

Resolution as amended was adopted.

A resolution was read by Dr. C. D. Christ of Orlando relative to legislation permitting fruit growers to use an arsenic spray to prematurely increase the sugar content of unripe fruit.

Dr. G. C. Tillman moved that this matter be deferred 24 hours, during which time the President appoint a committee of three to confer with the president of the Florida Citrus Exchange, the State Health Officer and the United States Plant

Commissioner for their opinion on this matter. Seconded and carried.

Dr. H. L. Bryans spoke briefly as to a proposed plan whereby the Florida Medical Journal might possibly be combined with the Journal of the Georgia and Alabama Associations. He then asked that the privileges of the floor be accorded Dr. A. G. Fort of Atlanta, Georgia, that he might further discuss this subject.

At the close of Dr. Fort's discussion, Dr. Anderson moved that the consideration of this plan be referred to the Executive Committee, to report back at a later date. Seconded and carried.

The following recommendations of the Executive Committee were read by Dr. Ho'den:

1. That the Association underwrite the finances of the Post-Graduate week to an amount not exceeding five hundred dollars to cover unexpected but possible deficiencies between receipts from registrations and traveling expenses of teachers.

Motion by Dr. L. M. Anderson that the above recommendation be approved, and that the committee on Medical Post-Graduate Course be authorized to expend up to $500.00 as designated. Seconded and carried.

2. That a committee be appointed to put into effect such phases as may be desirable of the "5-year plan" of the American Society for the Control of Cancer. That the Committee be composed of five members, appointed respectively for 5, 4, 3, 2, and 1 years, the vacancy to be filled each year by appointment of the President. Seconded and passed.

3. That the incoming president be authorized to appoint a Medical Economics Committee of 5 men—said committee to investigate and gather information on free clinics, free school examinations and other economic problems, cooperating with county society Economic Committees; the committee to report a uniform plan at the 1934 meeting of the State Association for its consideration and probable adoption.

4. That the Lee County Medical Society be given $50.00 to partially reimburse them for monies spent in prosecution proceedings against Dr. F. K. Armstrong.

Motion made, seconded and carried to reimburse the Lee County Society in the amount of $50.00.

5. That the House of Delegates authorize the Executive Committee to spend, upon the advice of the Association's legal counsel, in fighting appeals by convicted irregulars a sum not to exceed $200.00 in any one case, nor to exceed $600.00 in any one year.

Motion by Dr. L. M. Anderson that the above recommendation be granted, and that the Executive Committee be empowered to employ our regular counsel in such cases. Seconded and passed.

The Duval County Medical Society submitted the name of Dr. Charles L. Jennings of Jacksonville for honorary membership. Upon motion, duly seconded and carried, Dr. Jenning's name was referred to the Executive Committee to take the regular course.

The following resolution by Dr. H. E. Palmer was offered for consideration:

WHEREAS, The Florida Medical Association at its Annual Meeting in 1932 adopted a Resolution recommending that the 18th Amendment to the Federal Constitution should be submitted to a national referendum; and

WHEREAS, Since that time the Congress of the United States has submitted to conventions in the several States the adoption of the 21st Amendment to the Federal Constitution, whereby the 18th Amendment to the Federal Constitution is repealed, and further, the Congress of the United States has enacted legislation permitting the lawful sale of beer and other beverages of 3.2% alcoholic content, in such States of the Union as may see fit to permit the same; and

WHEREAS, The Legislature of the State of Florida has submitted to the electorate of the State, to be voted on at the general election of 1934, an amendment to Article XIX of the State Constitution, which will permit the sale of alcoholic beverages of higher content, under regulations to be prescribed by the Legislature; and the Legislature of the State of Florida has now pending before it for completion certain legislation sanctioning the sale of beverages of alcoholic content not exceeding 3.2% in the State of Florida under divers regulations, and subject to certain revenue to be derived by the State, and also has pending before it legislation for the creation of a convention to pass upon the ratification of the 21st Amendment to the Federal Constitution above mentioned; and

WHEREAS, The passage of another year has but emphasized the evils of our present system of dealing with alcoholic beverages, as pointed out by Resolution adopted by this Association in 1932;

BE IT RESOLVED:

1. That we heartily congratulate the Senators and Congressmen of the State of Florida who participated in supporting the submission of the said 21st Amendment to the Federal Constitution, and in supporting the legalization by the Federal Government of the sale of beer.

2. That we strongly urge upon the Legislature and the Governor of the State of Florida the speedy enactment of the legislation necessary to legalize the sale of beer and other beverages of alcoholic content not exceeding 3.2% in the State of Florida; and also the enactment of proper legislation providing for the election of delegates to a State Convention for the ratification of the 21st Amendment to the Federal Constitution, such delegates to be selected according to Congressional Districts and from the State at large, and not upon the basis employed for the election of representatives to the Florida Legislature, which last-mentioned basis is not proportionate to the population of the several counties and is, therefore, unfair.

3. That we urge upon our fellow citizens of the State of Florida, in electing delegates to such State Convention, to select those who by public declaration have

espoused the cause of repeal; that at the general election of 1934 by an overwhelming vote they affirm the action of the Florida Legislature in submitting to the people the proposed amendment to Article XIX of the State Constitution; for, in this manner, the thirteen-year reign of tyranny, oppression, crime and graft brought into being by the 18th Amendment to the Federal Constitution and Article XIX of the Florida Constitution will come to an end, and the cause of true temperance will be served.

4. That copies of this Resolution be supplied to the public press and sent to all Florida Senators and Congressmen, to the Governor of Florida, the President of the Florida Senate and the Speaker of the Florida House of Representatives; and that the Directors of this Association are authorized and requested to take all such further action as in their judgment is best calculated to further the objects approved by this Resolution.

Upon motion by Dr. Jack Halton, seconded and carried, the above resolution was adopted.

Motion by Dr. J. C. Vinson that a committee of three be appointed to devise means by which annual dues of our Association may be reduced.

Motion amended by Dr. Anderson that the committee be appointed by the President and to report back at the next meeting of the House of Delegates the following day.

Amendment accepted. Motion as amended prevailed.

On motion, meeting adjourned until 5:00 p. m. Wednesday, May 3rd.

SECOND SCIENTIFIC ASSEMBLY

Dr. Leland Carlton presiding.

The following papers were read and discussed:

"Appendicitis with Its Increasing Mortality," Herbert E. White, St. Augustine.

"A review of Some Urinary Anomalies and Pathologic Conditions Producing Symptoms of Especial Interest to the General Practitioner," Roy J. Holmes and M. M. Coplan, Miami.

"Carcinoma of the Colon," George M. Dawson, West Palm Beach.

SECOND GENERAL SESSION

The General Assembly reconvened at 10:30 a. m. Wednesday, May 3rd, with Vice-President Halton in the Chair.

The annual Presidential address was delivered by Dr. Gerry R. Holden.

An address (by invitation), "Brain Tumors, Their Diagnosis and Treatment," was delivered by Walter E. Dandy, Baltimore, Md.

An address (by invitation) was given by Sam R. Marks, Legal Advisor of the Florida Medical Association.

THIRD SCIENTIFIC ASSEMBLY

The following papers were read and discussed:

"Cerebral Injuries of the Newly Born," James H. Fellows, Pensacola.

"Placenta Previa," Homer L. Pearson, Miami.

"Granuloma Inguinale," R. B. Harkness, Lake City.

"Observation of Five Hundred Fractures," Joseph Halton, Sarasota.

"Fractures at the Ankle and Wrist Joints," W. M. Shaw, Jacksonville.

"Fractures of the Cervical Spine Below the Atlas and Axis with Report of Two Cases," George E. W. Hardy, Tampa.

SECOND MEETING OF THE HOUSE OF DELEGATES

The House of Delegates reconvened at 5:00 p. m. Wednesday, May 3rd, 1933, Hollywood Beach Hotel.

Roll Call by the Secretary.

Dr. J. C. Davis again called attention to the presence of two bills, designated as House Bill 773 and House Bill 774, reread these bills and urged the cooperation of each individual member of this Association in an effort to combat the passage of such bills by the Florida Legislature.

Dr. Holden then called for the report of the committee appointed to investigate the arsenic spray for grapefruit and tangerines, said committee consisting of Drs. G. C. Tillman, R. L. Cline and G. S. Osincup. Dr. Tillman, Chairman, gave the following report:

Your committee, since the meeting yesterday afternoon, have contacted the individuals mentioned, and all of the telegrams received are practically the same. Dr. Paul Eaton, of the State Board of Health, made the statement to us that their objection is not from the effect of the arsenic content in the fruit on the human body, but due to the fact that the arsenic affects the food value of the fruit. A telegram from the United States Department of Agriculture—which is typical of the others received—states that large quantities of arsenic sprayed on citrus fruit reduces vitamin "C". Small quantities increase solids, while large quantities decrease solids. They have no information showing that citrus fruit sprayed with arsenic in small quantities is injurious to human beings.

It is the opinion of this committee from their information, that so far as the Medical Profession is concerned this is not injurious to human health, and they recommend that the matter be tabled indefinitely.

Recommendation approved.

The committee consisting of Dr. W. M. Davis, St. Petersburg, Chairman; and G. H. Ed-

wards and H. C. Dozier, members, appointed to determine the possibility of a reduction in annual dues, reported as follows:

Your committee, appointed for the purpose of determining the possibility of reducing the annual dues in the Florida Medical Association, beg to submit the following report:

After careful study, and going through the finances of the Association as well as its major activity, the JOURNAL, we believe that it will be possible, through the generosity of the secretary-treasurer-editor and the business manager to make a saving of $2,400.00 in the gross expenses of the Association, which will mean a continuance of all present activities of the Association.

We believe the life of the Association, the enthusiasm and interest of its members, are absolutely dependent on the continuance of the Journal as a Journal of the Association.

We have been able to accomplish this reduction by the voluntary, generous gift of the secretary-treasurer-editor of his entire salary and also by a voluntary cut in salary on the part of the business manager of the Association, as well as other minor economies. In order that the saving mentioned above may be accomplished, it is recommended to the incoming Executive Committee that all economies possible be practiced in the administration of the various committee activities.

After a careful examination of the financial records of the business office and Journal, we found it extremely difficult to see where any economies could be instituted and were able to accomplish the above reduction only through the voluntary relinquishment of salary by the secretary-treasurer and a reduction in salary by the business manager.

While we believe that annual dues of $10.00 are not excessive and, in consideration of activities carried on by the Association, are not unreasonable, and in view of the present economic situation and the necessity for personal economy by the membership of this Association, we recommend that the annual dues be cut to $7.50 for 1934 and until the necessity for this reduction has passed.

We further recommend that such items as those proposed yesterday for the underwriting of the University of Florida Post-Graduate Medical Course and other appropriations such as funds to carry cases to the Supreme Court be taken from the surplus capital account because, with this reduction, they cannot be taken from the current income.

Your committee recommends that the first part of Chapter 8, Section 1, of the By-Laws, reading:

"An assessment of $10.00 per capita on the membership of the component societies is hereby made the annual dues of the Association"

be amended to read:

"An assessment of $7.50 per capita on the membership of the component societies is hereby made the annual dues of the Association."

(Signed) W. M. DAVIS,
(Signed) G. H. EDWARDS,
(Signed) H. C. DOZIER.

Motion by Dr. Jack Halton that the report of the committee be adopted, and that a vote of thanks be extended to the men who so generously volunteered to accept a reduction in salary. Motion seconded and carried.

Motion by Dr. L. M. Anderson that the House of Delegates reconvene tomorrow for a final vote on the proposed change in the by-laws. Seconded and carried.

On behalf of the Pinellas County Medical Society, Dr. A. L. Mills submitted for honorary membership the names of Dr. John D. Peabody of St. Petersburg and Dr. Andrew P. Albaugh of Tarpon Springs.

On motion by Dr. L. M. Anderson, seconded and carried, the names of these two doctors were referred to the Executive Committee to take the usual course.

Motion by Dr. H. C. Dozier that the Florida Medical Association go on record as commending the work of Dr. Henry Hanson, State Health Officer, with the suggestion that he be continued in this office in the future, and that this action be reported to the proper authorities.

The above motion was duly seconded and unanimously adopted.

Motion by Dr. L. F. Carlton that all members present send telegrams to the proper legislative committees in Tallahassee opposing the passage of house bills No. 773 and No. 774 and any other bills now before the Legislature which are objectionable to this Association. Seconded and carried.

Motion by Dr. G. C. Tillman that the Association express its thanks to Major Garland Powell for the cooperation of Station WRUF with the Medical Association. Seconded and carried

The House of Delegates then adjourned until the following day.

FOURTH SCIENTIFIC ASSEMBLY

The following papers were read and discussed:

"Use of Unsweetened Evaporated Milk in Infant Feeding," Warren Quillian, Coral Gables.

"Unilateral Exophthalmos with Case Report," Joseph W. Taylor, Tampa.

"Heart Disease of the Rheumatic Type," C. F. Roche, Miami Beach, and T. Duckett Jones, Boston, Mass.

"Hypothyroidism in Adolescent Girls with Particular Reference to Social Delinquency," T. Z. Cason, Jacksonville.

"Some Problems of Medicine," Henry C. Dozier, Ocala.

"A State Health Department's Service to the Medical Profession," Henry Hanson, Jacksonville.

THIRD GENERAL SESSION

The General Session of the Florida Medical Association again convened at 12:00 noon, May 4th, in the auditorium of the Hollywood Beach Hotel. The meeting was called to order by Dr. Gerry R. Holden of Jacksonville, President.

Dr. Holden announced that the first order of business would be the election of officers for the ensuing year, and appointed Drs. S. E. Driskell, W. M. Davis, H. L. Bryans, T. M. McDuffee, and Meredith Mallory to act as tellers.

Dr. Herman Watson of Lakeland was nominated for the Presidency by Dr. N. L. Spengler of Tampa. Nomination seconded.

Dr. W. M. Rowlett of Tampa was then nominated for President by Dr. Leigh F. Robinson, Ft. Lauderdale. Nomination seconded.

On motion duly made, seconded and carried, the nominations were closed.

It was moved and seconded that each man deposit his ballot at the desk and be checked to see if his dues had been properly paid. President Holden called for a rising vote. Motion passed.

Dr. R. C. Woodard of Miami moved the withdrawal of the foregoing motion.

Dr. Anderson suggested that the motion of Dr. Woodard be amended to read, "That the previous action be reconsidered, and that the Secretary ask the members of the Florida Medical Association who have paid their dues to come forward and vote, and the others please remain seated." Amendment accepted by Dr. Woodard. Seconded and carried.

Dr. W. M. Rowlett was elected President on report of tellers.

On motion by Dr. Herman Watson, duly seconded, Dr. Rowlett was declared unanimously elected President of the Association.

President Holden asked Dr. Leigh Robinson and Dr. L. M. Anderson to escort the newly elected President to the Chair

Dr. Holden: "Dr. Rowlett, I assure you that I wish you every success, and I am pleased to hand to you this gavel which our late President, Dr. Gaston Edwards, presented to me as President of the Florida Medical Association."

Dr. Rowlett: "Dr. Holden, Members of the Florida Medical Association, Ladies and Gentlemen: I wish to thank you for this great honor that you have placed upon me. I feel a great deal like the negro woman that went to the same lawyer that married her to get a divorce. She said, 'Judge, you married us, and now I want you to divorce me.' The lawyer turned to her saying, 'Mary, didn't you take Rastus for better or for worse?' She said, 'Yes, sir, I took him for better or for worse, but he is worse than I took him for.' So I hope at the end of my administration you won't find it thus."

Dr. Holden relinquished the Chair to his successor, who continued with the election of officers.

Dr. Homer L. Pearson of Miami was nominated as President-elect by Dr. J. C. Davis.

Dr. Leland Carlton made a motion that the nominations be closed and the Secretary instructed to cast the unanimous ballot of this Association for Dr. Pearson. Seconded and carried.

President Rowlett appointed Dr. Gerry Holden to escort the newly elected President-elect to the rostrum.

President Rowlett appointed Dr. Gerry Hollate you upon this great honor that has been bestowed upon you, and wish you 'God speed'."

President-elect Pearson: "Gentlemen, I am going to be more or less before you for two years, and before that time is up I am afraid that a number of you will say, 'For God's sake, sit down,' and so I am going to suggest that some of you make that a motion now."

The Chair then called for nominations for First Vice-President, and Dr. J. W. Alsobrook nominated Dr. G. C. Tillman of Gainesville.

Upon motion of Dr. Leigh Robinson, duly seconded and carried, the nominations were closed, and Dr. Tillman unanimously elected.

Dr. L. M. Anderson nominated Dr. J. Ralston Wells, Second Vice-President, and moved that the Secretary be instructed to cast the ballot. Seconded and carried.

Dr. Walter Jones nominated Dr. H. J. Peavy of Hollywood, Third Vice-President. On motion made, seconded and carried, Dr. Peavy was given unanimous vote.

Dr. Jack Halton offered a motion that the Association unanimously re-elect Dr. Shaler Richardson of Jacksonville Secretary and Treasurer. Seconded and carried.

President Rowlett appointed Dr. L. M. Anderson of Lake City to escort Dr. Gerry R. Holden to the rostrum and present to him the past president's emblem.

Dr. Anderson: "Mr. President, Members of the Florida Medical Association, Ladies and Gentlemen: It is once in a while in a young man's life like mine, that he comes to a pleasure like this, and he receives pleasant thoughts from the boys —like Gerry here. Now, you all know that it is no use for me to try to tell you what kind of a President he has been. They even tried to keep him running on and on. I take great pleasure in presenting to you, Dr. Holden, this button, the badge of the Florida Medical Association to its past presidents. You are standing now before this Association as the most honored member of this organization. You have given your time, your brains and your best efforts. Gerry, even during this meeting you have told me to sit down and would not let me talk when I wanted to, although they say I always talk. I hope, sir, that you will wear this for years and think what these colors mean. Gold means true, yellow means your fidelity to your country and your profession, and green for your growth in the Association."

Dr. Holden: "I thank you, Dr. Anderson."

Dr. Richardson announced that the Association had completed all business, and on motion duly made, seconded and carried, the meeting adjourned, *sine die*.

THIRD MEETING OF THE HOUSE OF DELEGATES

The House of Delegates reconvened at 1:00 p. m. Thursday, May 4th, 1933, with Dr. W. M. Rowlett presiding.

Motion by Dr. L. M. Anderson that the roll call be dispensed with, seconded and carried.

The suggested change in the By-Laws, which had laid on the table for one day, was then taken up for final consideration. The Secretary was asked to read the proposed change, which was as follows:

"That the first part of Chapter 8, Section 1 of the By-Laws, reading: 'An assessment of $10.00 per capita on the membership of the component societies is hereby made the annual dues of the Association' be amended to read: 'An assessment of $7.50 per capita on the membership of the component societies is hereby made the annual dues of the Association'."

After open discussion, it was moved by Dr. J. Ralston Wells that the change in By-Law be adopted. Seconded and carried.

There being no further business, the meeting adjourned.

REGISTRATION

The total registration during the Sixtieth Annual Meeting of the Florida Medical Association, held in Hollywood May 2nd, 3rd and 4th, was 464; members, 323; visitors, 30; exhibitors, 14; Woman's Auxiliary, 97.

Officers

HOLDEN, GERRY R., President.....Jacksonville
HALTON, JACK, First Vice-President.....Sarasota
PEEK, EUGENE G., Second Vice-President.....Ocala
RICHARDSON, SHALER, Secretary-Treasurer...Jacksonville
THOMPSON, STEWART, Business Manager....Jacksonville

Alachua County Medical Society

Maines, John E., Jr. Gainesville
Tillman, George C. Gainesville
Whitaker, C. D. Raiford

Brevard County Medical Society

Bean, I. F. Melbourne
Hay, I. M. Melbourne
Kenaston, T. C. Cocoa
Page, Walter C. Cocoa
Potthoff, E. W. Titusville

Broward County Medical Society

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone 5-0577

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OUR PRESIDENT

Dr. William M. Rowlett was born in Collierville, Tenn., May 17, 1884. At the age of one year he moved to Florida with his parents. His preliminary education was received in the public schools of Manatee County. He graduated from the University of Florida in 1906, receiving the degree of Bachelor of Science. During his last year in Florida, he was elected President of the Athletic Association and the local chapter of the Pi Kappa Alpha literary fraternity. In 1909 he graduated with the degree of M. D. from the medical department of Emory University. Following his graduation, he was appointed House Surgeon to the Atlanta Presbyterian Hospital. Early in 1910 he moved to Tampa, where he became associated with the late Dr. John S. Helms, which association lasted until 1921, when he left Florida to spend several months doing special study at Harvard Medical School. After returning to Tampa, he restricted his practice to obstetrics and gynecology, heading that section at the Bayside Hospital, serving as gynecologist to the Tampa Children's Home for the past twelve years, and the head of the section on gynecology and pelvic surgery at the new Tampa Municipal Hospital.

In 1913 Dr. Rowlett married Miss Gregory Walker of New York City. He is a member of the American, Southern and Florida Medical Associations, a Fellow of the American College of Surgeons and the Southeastern Surgical Congress. He is also past president of the Tampa Kiwanis Club, and past Potentate of Egypt Temple of Shriners. He took the leadership in having the act passed by the legislature of 1921, creating the Composite Board of Medical Examiners, and in 1927 the annual Registration Act. He has served continuously as secretary of the Composite Board of Medical Examiners since its creation.

Dr. Rowlett became nationally known among the medical men in 1926 when he took an active part in breaking up the notorious bogus diploma mills that flourished so thrivingly throughout the United States, and which resulted in the indictment by the Federal Grand Jury of eighteen Florida physicians. Dr. Rowlett's familiarity with the aims of the Association, gained through many years of service on the Committee on Legislation and Public Policy, and his personal acquaintance with a large proportion of the membership will do much to make his term as President an outstanding success.

THE HOLLYWOOD MEETING

The Broward County Medical Society, acting as host for the Sixtieth Annual Meeting of the Florida Medical Association, held in Hollywood May 2nd, 3rd and 4th, is to be congratulated for making possible one of the best attended and most enjoyable meetings in the history of the Association. Although Hollywood is not centrally located, the attendance was unusually large—in fact, the records show it to be among the first in rank for total attendance.

The local committees were appointed far in advance and the members of each committee worked hard prior to the meeting as well as during the entire convention. One unusual advantage the entertaining society had over those in the past was the exclusive rights to the magnificent Hollywood Beach Hotel. The setting was perfect and the freedom to this wonderful hostelry, with its manifold luxuries and conveniences, was in itself worth the trip.

The banquet was unusually well attended and the large dining room was more than ample to take care of all those who wished to attend. The menu at the banquet was well selected; the service and food of the highest order. The program and entertainment during the banquet were interesting and spicy. The plans for the evening's entertainment were carried out beautifully.

The golf tournament proved to be quite a success as forty doctors in all took part. The silver loving cup, donated by the Orange County Medical Society, was won by Dr. B. W. Lowry of Tampa; the second prize, a beautiful genuine leather surgical bag, donated by Mr. Henry Parramore of the Surgical Supply Co., was won by Dr. Joseph Halton of Sarasota.

Among other delightful attractions in the entertainment program were: fishing, surf bathing, dancing, bridge and a boat trip on an ocean liner.

As the complete proceedings of the meeting appear in this issue of the Journal, little, if any, comment is necessary regarding the business which transpired. It will be noted that there were three meetings of the House of Delegates instead of the usual one meeting. The scientific program was well carried out; every paper which appeared on the program was read and discussed. The presentation of "Brain Tumors, their Diagnosis and Treatment" by our distinguished guest of honor, Dr. Walter E. Dandy of the Johns Hopkins Hospital, Baltimore, Maryland, was of unusual interest. His subject in the form of a lecture was illustrated with numerous lantern slides.

APPROVED HOSPITALS IN FLORIDA

Compliance with the minimum requirements for standardized hospitals in the state, as recommended by the Hospital and Medical Education Committee, enables a hospital to appear on the approved list of the Association. It is anticipated that this list will be published annually in the Journal of the Association. Any hospital that is approved by the American College of Surgeons will be automatically included in this approved list. There have been very few changes in the list which was published last year.

The following approved list of hospitals was submitted to the Journal for publication by the Medical Education and Hospital Committee, composed of Dr. Walter A. Weed, Lakeland, chairman; Dr. R. O. Lyell, Miami, and Dr. Harry F. Watt, Ocala. Any information regarding hospitals in the State of Florida should be referred direct to the Association's Medical Education and Hospital Committee.

APPROVED HOSPITALS IN FLORIDA

City	Hospital	Rating
1. Century	Turberville	FA
2. Clearwater	Morton F. Plant	FA
3. Daytona Beach	Halifax District	FA
4. Ft. Lauderdale	Memorial	CA
5. Gainesville	Alachua County	FA
6. Gainesville	University of Florida Infirmary	FA
7. Jacksonville	Brewster	FA
8. Jacksonville	Duval County	FA
9. Jacksonville	Riverside	FA
10. Jacksonville	St. Luke's	FA
11. Jacksonville	St. Vincent's	FA
12. Key West	U. S. Marine	FA
13. Lake City	Veteran's Administration	FA
14. Lakeland	Morrell Memorial	FA
15. Miami	Dade County	FA
16. Miami	James M. Jackson Memorial	FA
17. Miami	Victoria	FA
18. Miami Beach	St. Francis	FA
19. Ocala	Munroe Memorial	FA
20. Orlando	Orange General	CA
21. Orlando	Orlando-Florida Sanitarium & Hospital	CA
22. Pensacola	Pensacola	FA
23. Pensacola	U. S. Naval	FA
24. St. Augustine	East Coast	FA
25. St. Augustine	Flagler	FA
26. St. Petersburg	City Hospitals (Mound Park-Mercy)	FA
27. St. Petersburg	St. Anthony's	FA
28. Tallahassee	Florida A. & M. College	CA
29. Tampa	Children's Hospital of Tampa	FA
30. Tampa	Tampa Municipal	FA
31. W. Palm Beach	Good Samaritan	FA

FA—Fully approved.

CA—Conditionally approved.

RADIO BROADCASTS, 1932-1933

The following broadcast was arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

SMALLPOX*

Louie Limbaugh, M.D.,
Jacksonville.

As far backwards into the history of the world as students may delve, there is the eternal story of conflict of man against his enemies.

The nations of the earth have diminished their population by untold numbers in wars and conquests. But always, in the book of history, there stands out the story of the conflict of all men and nations against disease. Several hundred years ago, there were many and disastrous plagues and epidemics of various diseases, which took a toll far in excess of the battlefield. Other diseases were constantly raging with a death-rate that was appalling. Outstanding among these endemic diseases stood smallpox. For hundreds of years prior to the nineteenth century, smallpox was the most prevalent and feared of diseases. It has been thought by some students that the terrific "Plague of Athens" in 430 B. C. was none other than this scourge. For centuries the disease ran rampant. In the eighteenth century, in Europe alone, sixty million people died of it. Everyone expected to have it at some time or another. It attacked chiefly children, and on this account the Germans called it "childpox." Of those who contracted it, one out of twelve died, and of those who survived, most were badly disfigured. It is against this disfigurement that Ben Johnson wrote his famous but then futile protest:

"Envious and foul disease, could there not be
One beauty in an age, and free from thee?"

Smallpox was no respecter of persons. It attacked the high and the low alike. William the Third of England lived to carry the marks of the disease on his face and body, but not so his mother, father, wife, uncle and two cousins, for the death certificates of that day read "smallpox." Louis XV of France died of smallpox in 1774. He was the last ruler of a civilized nation to die of this disease.

That the world today can read and hear of such tragedies without fear or tremor is due to the

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, November 20, 1932.

ingenuity and zest of an English country physician. The name of Edward Jenner is destined to live forever. It was he who put the theoretical linking together of cowpox and human smallpox to a practical test and gave to the world a discovery which could and can completely eradicate the disease from the face of the earth, an achievement comparable to the discovery of America.

A system of inoculation, crude, of course, and ineffectual accordingly, was known to the ancient Chinese and other orientals. The first recorded instance of such prophylactic procedure in England was in 1717, when the practice of inoculation was introduced into the native land of Jenner by Lady Mary Wortley Montagen, wife of the British ambassador to Constantinople. Catherine the Great introduced the practice into Russia. She and her son were both inoculated. They then exposed themselves to smallpox to demonstrate the efficacy of this preventive measure. During the American Revolutionary War, George Washington required all recruits to the army to be inoculated unless they had already had smallpox. In 1774, there occurred the first successful vaccination. It had been noted and commented upon that dairy maids who contracted cowpox from cattle seemed immune to smallpox, and acting upon this knowledge an English farmer successfully transferred cowpox virus to a human being in that year.

In 1791, a German physician vaccinated three children. Inoculation of humans with disease was not uncommon in those days on the theory that a mild attack so caused would render the individual immune to a more serious form of the disease. It was the ambition of Edward Jenner to inoculate the virus of cowpox into humans and so prevent the dreaded disease smallpox in any form. In May, 1797, a dairy maid infected with cowpox came under Jenner's care. He transferred some of the cowpox virus from the hand of this maid to the arm of an eight-year-old boy, James Phipps. The result was a typical vaccination "take". Then followed the real test. In July of the same year, James Phipps was inoculated with the virus from a human case of smallpox, and James did not develop smallpox. The experiment was repeated a few months later with the same results. James was immune as are thousands and thousands of little "James" of our own day. Jenner then confirmed his test by inoculating with smallpox ten persons who had previously had cowpox. None developed the disease and his enthusiasm and faith were thus increased a literal tenfold. His opinions were published two years later and were received with enthusiasm by our own forefathers, who had been seriously molested by the ravages of smallpox throughout the days of the colonies and the revolution. In 1800 we find recorded the first known vaccination in America when Dr. Benjamin Waterhouse of Boston vaccinated his own five-year-old son. Two years later, another physician of the same city, whose memory is today promulgated by the name of one of Boston's principal streets—Boylston—vaccinated nineteen boys and later inoculated them with smallpox to find nineteen successful tests. Two other boys exposed to smallpox and not having been vaccinated, contracted the disease and stimulated the Board of Health of that city, of which Paul Revere was president, to conclude that "cowpox is a complete security against smallpox".

The practice of vaccination grew rapidly and soon thousands of persons were inoculated, and the procedure proved to be a complete protection without exception. In 1805, Napoleon ordered universal vaccination of the men of his armies. In 1806, Dr. Jenner received a letter of enthusiasm and praise from the vaccinated arm of our own Thomas Jefferson. By 1870, the world had become arrogant as regards to its susceptibility to the omnipresent dread. The disease had been crowded to the background by over a half a century of widespread vaccination. Such an "out of sight, out of mind" attitude was given a severe jolt following the Franco-Prussian war, when there occurred a violent outbreak of smallpox. Again vaccination came into its own. History has repeated itself several times since. The world too easily assumes a false sense of security. Nor is our own state immune to such neglect. In the year 1900, there were 1,000 cases of smallpox in three counties, of which the name Alachua is prominent. Then came a lull in such statistics.

Again, in 1926, there were reported 2,890 cases of smallpox in the State of Florida, and in 1927 over 1,350 reports mar our record. For contrast in numbers, there were 284 cases of smallpox in the entire State of Florida from January, 1928, to September, 1932. The influence of Edward Jenner, country physician of England in the latter part of the eighteenth century, is being felt here in our own state as it is wherever the long finger of civilization points. The security of health is broadened by his teachings. True, the technique

of vaccination is so improved and the manufacture of the virus is now accomplished with such skill and purity as to have been unhoped for by Jenner, yet it is to him, primarily, that a mother today can give thanks that her three-months-old babe can be safely and literally painlessly protected from the "pitiless plague" of yesteryear.

STATE NEWS ITEMS

The many friends of Dr. E. W. Warren of Palatka will regret to learn of the death of his wife, on April 18th. Besides her husband, Mrs. Warren is survived by three sons, Brandon Warren of New York City, Lamar Warren of St. Augustine, and Walter Warren of Palatka.

* * *

The American Proctologic Society will meet in Chicago, June 12th and 13th. The Stevens Hotel will serve as headquarters. This society was organized in 1899 for the purpose of "investigating and disseminating knowledge relating to the rectum, anus and colon."

* * *

Dr. Aaron Oberdorfer of Jacksonville recently addressed the members of the Masonic Club on "Some Aspects of Disease Prevention."

* * *

At the close of the annual meeting of the Association, representatives from Palm Beach, Broward and Dade Counties, met with state and government health officials for the purpose of organizing to assist the Federal Government to better the mosquito conditions in the three counties. Now that the Florida State Coast Canal is being deepened and widened, the engineers are willing to help in the mosquito work, providing the city and county commissioners supply the tools and transportation for the workmen.

* * *

At the 1933 Graduate Fortnight of the New York Academy of Medicine, metabolic disorders will be the theme. Two weeks of intensive study, from October 23 to November 3, inclusive, will be devoted to this important branch of medical science. The theoretical, physiologic and pathologic phases of metabolism, as well as of certain of the associated endocrinologic problems will be treated in a series of round table discussions and clinical demonstrations.

* * *

Dr. V. K. Jindra of Miami was convicted and sentenced to three years in the Federal penitentiary on May 18th, on a narcotic charge. He has filed notice of appeal.

* * *

Dr. C. C. Collins of Jacksonville has again been the victim for thieves. A new automobile was stolen from Dr. Collins on the evening of May 11th, while he was in St. Luke's hospital. The car was later recovered. On February 1st, Dr. Collins' instruments were taken from his car; on March 4th, his license tag was taken, and on April 15th another automobile was stolen, which was also recovered.

JOSEPH MAX IRWIN

Dr. J. M. Irwin of St. Augustine died suddenly while making a professional call in Jacksonville on April 19th. His death was attributed to a heart attack.

Dr. Irwin was a graduate of the Washington University School of Medicine, St. Louis, class of 1902. The following year he was licensed to practice his profession in Florida. For the past twenty years he has been located in St. Augustine. Dr. Irwin was a member of the Veterans of Foreign Wars, member of the staff of the Flagler Hospital, the St. Johns County Medical Society, the Florida Medical Association and a Fellow of the American Medical Association. He is survived by his invalid wife.

MILTON WALTON

Dr. Milton Walton of Hastings died on April 23rd, following a heart attack.

Dr. Walton was born in Lumpkin, Ga., attended schools in that city and also in Atlanta. He graduated from the University of Tennessee Medical School in 1904. He practiced in Lumpkin for many years and came to Hastings in 1927. He was a member of the St. Johns County Medical Society, the Florida Medical Association, the Southern Medical Association and a Fellow of the American Medical Association; a member of the Baptist Church of Hastings, the American Legion and the Masonic fraternity. He served overseas for two years with the U. S. Medical Corps.

Dr. Walton is survived by his widow and one son, Milton, Jr.

Dr. Ira W. Ballard of Miami was recently sentenced to two years in the Atlanta Federal penitentiary for violating the government narcotic laws. He was convicted of misuse of physicians' forms supplied for obtaining narcotics for use in medical practice.

* * *

The beautiful home of Dr. S. A. Morris of Jacksonville, located in Granada, was recently destroyed by fire. The loss was estimated at $100,000. Dr. Morris is making plans to rebuild in the very near future.

Drs. Charles Cleghorn, Nelson Pearson and Rothwell Lefholz of Miami were recent visitors in Nassau. They flew over via Pan-American Airways.

* * *

The Interne Committee of the Jackson Memorial Hospital recently announced the appointment of Drs. Cleveland Hoskins and McClamrock as resident house physicians for the coming year.

* * *

The third annual meeting of the Florida Heart Association was held in Jacksonville May 19th. The following officers were elected:

President—W. C. Blake, M.D., Tampa.

First Vice-President — Louie Limbaugh, M.D., Jacksonville.

Second Vice-President — E. Sterling Nichol, M.D., Miami.

Secretary-Treasurer — George L. Cook, M.D., Tampa.

Executive Director—Sherwood Smith, Jacksonville.

Drs. M. Jay Flipse, Miami; Spencer Folsom, Orlando; Henry Hanson (advisory), Jacksonville, and Mrs. M. L. Stanley (advisory), Jacksonville, were re-elected as members of the Executive Committee. Dr. Frank C. Metzger of Tampa was named chairman of the Scientific Committee.

One important feature of the scientific session of the Association was a discussion of blood pressure changes on moving to Florida from northern states. Discussions were also held on tubercular tests.

YOUNG MARRIED PHYSICIAN, well trained, including post-graduate work, desires position as associate or assistant. Write number 5836, care Journal, Box 81, Jacksonville.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held May 5th, 8:30 p. m., at the Huntington Club Rooms, the following program was given:

"A Business Man's Views of Current Events" (30 min.), Mr. Joe H. Gill, President Florida Power & Light Co.

"Abnormalities of the Vertebral Bodies" (15 min.), Gerard Raap, M.D., Miami.

Dade County Medical Society reports that the attendance at its April meeting was splendid.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

At the April meeting of the DeSoto-Hardee-Highlands County Medical Society, held at Sebring, Drs. E. W. Bitzer, C. A. Andrews, J. C. Dickinson, Frank C. Metzger, and Wm. M. Rowlett of Tampa were guests of the Society. Dr. Bitzer presented a paper on "Essential Hypertension" which was liberally discussed.

At the May meeting, held in Avon Park, May 9th, Dr. M. C. Kayton of Wauchula read a paper on "Sinusitis", which was discussed by all members present.

DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held at 8:15 p. m., April 21st, at the Mayflower Hotel, Jacksonville. The scientific program was in charge of Dr. O. E. Denny of the United States Public Health Service. His subject was "Leprosy," illustrated with natural color pictures. During the business session, it was decided to invite the Florida Medical Association to hold its 1934 meeting in Jacksonville.

A great deal of favorable comment has been evoked by the "Baby" edition of the Florida Times-Union, which made its appearance on Sunday morning, April 30th. This issue contains the following articles, each bearing the notation "Written by Member of Duval County Medical Society":

"No Pattern Devised for Appetite of Each Child."

"Proper Food Should Make Baby Happy and Healthy."

"Quality Standard of Milk in Jacksonville is High."

"Immunization is Discussed."

"Rate of Infant Mortality is Steadily on Decrease."

There was also a splendid article headed "Medical Society Sponsors Program on Health Matters. Articles Will Be Written by Members of Society." It is a commendation of the work of the Society and contains a list of its members.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The Pasco-Hernando-Citrus County Medical Society met with Dr. G. R. Creekmore of Brooksville, Florida, Thursday evening, April 13.

Dinner was served at Tangerine Hotel, followed by our scientific meeting. Regular routine business was transacted, followed by five very interesting case reports with general discussion.

Dr. W. Wardlow Jones, formerly of Atlanta, Georgia, but now located in Dade City, Florida, was elected to membership in our County Medical Society and Florida Medical Association.

Dr. T. F. Jackson of Dade City, Florida, invited the Society to meet with him May 11, 1933.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, Inc.

State Editor
Mrs S. E. Driskell
1410 Windsor Place
Jacksonville, Florida.

OFFICERS

Mrs. E. G. Peek, President *Ocala*
Mrs E. R. McMurray, President-elect *Bartow*
Mrs. E. W. Veal, Vice-President *So. Jacksonville*
Mrs. Wilburn Lassiter, Secretary-Treasurer . . . *Gainesville*
Mrs. Robert M. Harris, Historian *Miami*

COMMITTEE CHAIRMEN

Mrs. A. L. Mills, Program *St. Petersburg*
Mrs. J. Ralston Wells, Public Relations . . . *Daytona Beach*
Mrs. H. Quillian Jones, Hygeia *Ft. Myers*
Mrs. S. E. Driskell, Press and Publicity *Jacksonville*

AUXILIARY NEWS

The seventh annual meeting of the Woman's Auxiliary to the Florida Medical Association was called to order by the president, Mrs. Leigh F. Robinson, at 9:30 a. m. in the men's card room of the Hollywood Hotel, Hollywood, Fla., May 4th, 1933. This lovely room was filled with bowls and baskets of beautiful spring flowers through the courtesy of the members of the Broward County Medical Auxiliary.

Following the invocation by the Rev. Thomas Sprague of Ft. Lauderdale greetings and the welcome address were given by Mrs. D. E. Carter of Ft. Lauderdale to which Mrs. Herrman H. Harris of Jacksonville graciously responded.

Dr. Gerry Holden, President of the Florida Medical Association, and Dr. Frederick Herpel of West Palm Beach, Chairman of the Advisory Committee to the Auxiliary, were introduced by Mrs. Robinson and each extended greetings and gave a short and interesting talk on the possibilities and aims of auxiliary work.

Mrs. J. A. Johnson of the Broward County Auxiliary presented a lovely basket of flowers to the president, Mrs. Robinson, a bouquet of roses to Mrs. Gerry Holden, wife of the President of the Medical Association, and a corsage to Mrs. D. E. Carter, General Chairman of the Local Committee on arrangements.

The reports of the Officers, chairmen of standing committees and delegates from the county auxiliaries were very interesting and showed much constructive work being done. Special attention was given to the report of the Public Relations Committee, Mrs. J. Ralston Wells, Chairman, of the lectures given by Dr. Arthur Cramp of the American Medical Association. Four lectures were given by Dr. Cramp in the state during the month of March.

The report of the nominating committee was read by Mrs. E. G. Peek of Ocala, in the absence of the chairman, Mrs. J. M. Irwin of St. Augustine, and the following officers were elected to serve during 1933-1934.

President—Mrs. E. G. Peek, Ocala.
President-Elect—Mrs. E. R. McMurray, Bartow.
Vice-Pres.—Mrs. E. W. Veal, So. Jacksonville.
Sec'y-Treas.—Mrs. Wilburn Lassiter, Gainesville.
Historian—Mrs. Robert M. Harris, Miami.

Mrs. Robinson very graciously presented the gavel to the new president, Mrs. Peek, who in turn introduced her official family and named the chairmen of standing committees for the new year:

Hygeia Committee—Mrs. H. Quillian Jones, Ft. Myers.
Program Committee—Mrs. A. L. Mills, St. Petersburg.
Press and Publicity—Mrs. S. E. Driskell, Jacksonville.
Public Relations—Mrs. J. Ralston Wells, Daytona Beach.

The meeting adjourned to meet in Jacksonville in 1934.

The registration of those who attended the State meeting at Hollywood appears on page 502 of this Journal.

ADVERTISERS' NOTES

False Rumors Concerning Viosterol Denied by Dr. Steenbock

A STATEMENT BY MEAD JOHNSON & COMPANY

Ever since viosterol was offered to the medical profession about 4 years ago, it has been attacked by various persons. Some of these attacks no doubt were sincerely motivated, but others were seized upon and exaggerated by interests who had no viosterol to sell.

Recently a new form of anti-viosterol propaganda has been reported by physicians all over the country. It is circulated by word of mouth—never in writing—and the apparent purpose is to influence physicians to prescribe vitamin D agencies other than viosterol.

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Physicians are being told, for example, that Dr. Harry Steenbock has "condemned" viosterol, that the Wisconsin Alumni Research Foundation "would withdraw viosterol from the market in 90 days," etc., etc.

In answer to these malicious untruths, Dr. Harry Steenbock makes the following statement:

"Viosterol in its various forms has to date been found fully as valuable in medical practice as was anticipated at the time that it was first introduced to the American markets. Up to the present time there have been no reports of any untoward effects from its administration, although originally it was anticipated from the results of animal experiments that some cases of intoxication might result from its use in human medicine. . . . I see no necessity for reversing my original opinion as to its outstanding merits in any way whatsoever. Any statement to the contrary can be definitely labeled as false." (Signed) H. Steenbock.

Physicians can draw their own conclusions and form their own opinions of any house that resorts to sharp practices by allowing its representatives to spread unfounded whispering campaigns against a valuable therapeutic agent that has endured four years of the most searching experimental investigation and clinical use not only in rickets but also for controlling calcium-phosphorus metabolism generally.

COCOMALT

The tendency to give milk to excess in post-operative and convalescent cases is apt to give the patient a feeling of revulsion. Yet milk is the one food for which there can be no effective substitute.

Modern physicians overcome this aversion to milk—this distaste for a steady milk diet—by flavoring it in a way that makes the color and taste interesting to the patient, yet does not alter the basic fundamentals of the milk itself.

Cocomalt, for example, converts milk into a delicious chocolate flavor food-drink that is tempting to the fussiest invalid. Even those who actually dislike milk and refuse to drink it, welcome the refreshing flavor of Cocomalt. Not only does it tempt sick and lagging appetites by its palatability: *Cocomalt substantially increases the nutritive value of milk.* Every cup or glass of Cocomalt a patient drinks is equal in food-energy value to almost two cups or glasses of milk alone.

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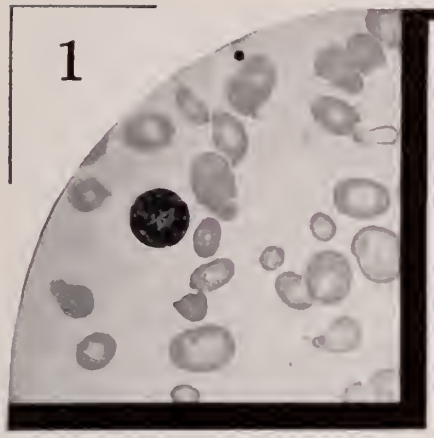
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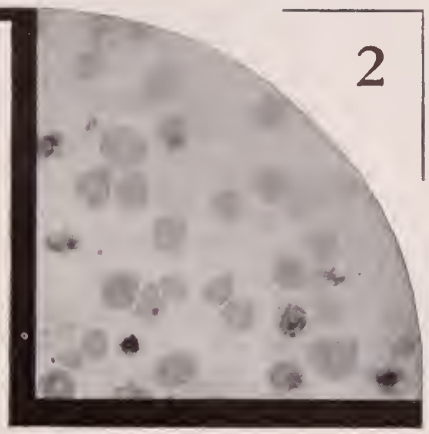
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1



At left—Pernicious Anemia pretreatment level. R. B. C. 820,000 per cu. mm.; Hb. 17%. Started Ventriculin 40 Gm. daily.

At right—Fourth day of treatment. Reticulocytes 54%; R. B. C. 1,120,000 per cu. mm.; Hb. 24%.



2

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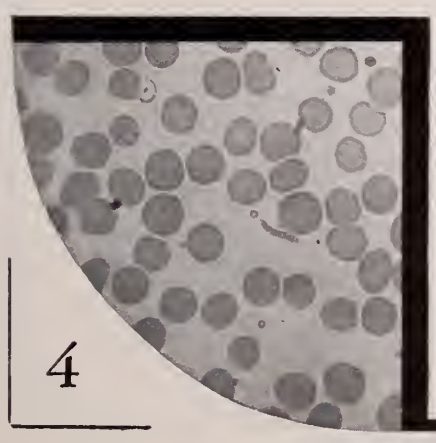
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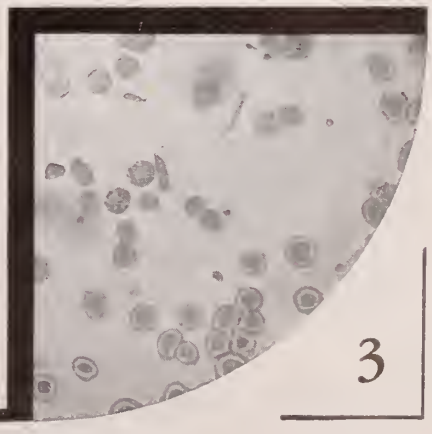
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4

At right—Seventeenth day of treatment. R.B.C. 2,440,000 per cu. mm.; Hb. 56%.

At left—Sixty-sixth day of treatment. R.B.C. 4,610,000 per cu. mm.; Hb. 84%.



3

even by the very sick. It is easily digested and quickly assimilated even by those whose digestive systems are impaired.

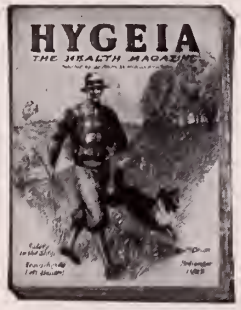
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COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	J. Maxey Dell, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	
Bay						
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	
Hillsboro	C. W. Bartlett, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel Bradenton	Yes.	
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	Louis Orr, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	James L. Carlisle, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg St. Petersburg	No.	
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital Sanford		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	

NOTE—Secretaries: Please submit information to complete the above schedule.

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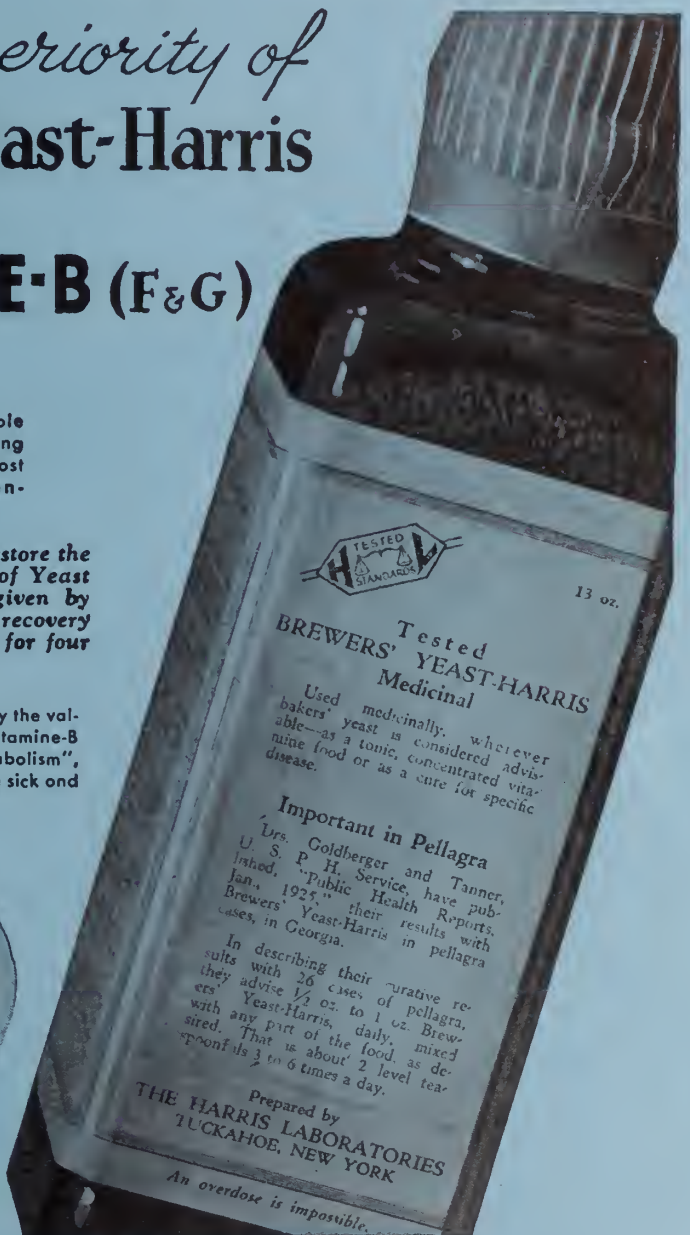
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VOLUME XIX
NO. 12

Jacksonville, Florida, June, 1933

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PUBLISHED MONTHLY

Volume XIX | Jacksonville, Florida, June, 1933 | Number 12

THE SIGNIFICANCE OF SYMPTOMS AND SIGNS IN LOBAR PNEUMONIA*

J. H. Bickerstaff, M.D.,

Pensacola.

The study, at the bedside, of symptoms and signs in a case of lobar pneumonia is more fruitful if undertaken with the purpose of obtaining helpful indications for treatment and for prognosis.

For the purpose of treatment and of prognosis we are especially anxious to get information, as to:

I. The extent, type, and severity of the infection.

II. Character and the extent of interference with the functions of respiration.

III. The status of the circulation.

There was a time when the bedside study of a case of pneumonia was capable of yielding all the information concerning the extent, type, and severity of the infection which the most careful physician required for the best use of the therapeutic agents then available. It must be acknowledged at the outset that this is no longer true. In those days our therapeutic efforts against the infection were limited to non-specifics. Today, however, we are in the period when specific sera are already available and are being rapidly improved.

There is no doubt that the future of the treatment of pneumonia lies with this form of therapy. Its proper use, however, requires knowledge of the type of pneumococcus involved and of its presence or absence in the blood stream. These are not facts that can be learned at the bedside. Nevertheless, we can learn at the bedside of the pneumonia patient a great deal which is helpful concerning the extent and severity of the infection. The data so gained are quite as indispensable as the laboratory data. Only the laboratory, for instance, can tell us whether bacteremia is present, but only study of the patient will inform us whether this bacteremia has led to a secondary meningitis, arthritis, peritonitis, or pericarditis. It is very important to estimate the extent of the consolidation in the lungs and its progress. The prognosis bears a direct relation to the number of lobes involved.

The toxemia of the disease cannot be accurately measured, but we can estimate its severity by the presence or absence of certain of its effects. Consideration of the mental state of the patient is helpful in estimating toxemia. A clear and tranquil mind in the later days of the disease is most reassuring; whereas, mental cloudiness or delirium, especially if with a low degree of fever, is of dangerous significance. Where marked cyanosis is present, some of the mental changes may be attributive of the lack of oxygen, and so be susceptible of relief by giving oxygen.

The toxemia of the disease is also measurable, to some extent, by the condition of the digestive tract. Persistence of vomiting after the onset, gastric distension, hiccups, severe intestinal distention with constipation and depleting diarrhea may be observed as severe toxemia.

Other evidences of toxemic damages, such as meningitis and albuminuria, have little relation, apparently, to the severity or prognosis of the disease.

Toxemia plays a very important part in the disturbances of the respiratory mechanism, but other factors play a role here, too, and the part due to toxemia cannot be accurately assigned. Discovery of the evidence of serious toxemia, as evidenced by mental and gastric intestinal manifestation, should lead to active efforts to increase elimination through the various channels by the forcing up of the fluid intake. At the same time treatment of the symptoms may be urgently indicated. It must, however, be stressed again that even in the present rather unsatisfactory status of serum therapy in pneumonia we are not giving our patient all the aid possible in combating his infection if we do not use serum treatment when it is indicated. It has been my custom to use the serums in all types; however, the general idea is to use serums only in type I.

CHARACTER AND EXTENT OF THE INTERFERENCE WITH THE FUNCTIONS OF RESPIRATION

The interference with the changes of oxygen and carbondioxide in the lungs and secondarily

*Read before Escambia County Medical Society, Pensacola, March, 1932.

throughout the entire body in pneumonia constitutes one of the most serious aspects of this disease. It is an effect of the disease which can be combated with some success by proper therapy. Therefore, a real obligation on the part of the physician is to study with care the symptoms and signs which throw light upon the character and extent of the interference with gas exchange present. The study of experimentally produced dioxide shows that it leads to an attempt at compensation by increased respiration and that as the dioxidation becomes more severe, the pulse accelerates, the blood pressure falls, cardiac irregularity develops, and headache, drowsiness and delirium appear. At a certain stage in progressive dioxidation, cyanosis of the skin and mucous membranes become apparent due to the increased proportion of dioxidation or venous blood in the superficial vessels.

In pneumonia as in experimental anoxemia, there is to be observed an apparent attempt at compensation by means of rapid breathing; if the compensation fails and anoxemia increases, cyanosis appears and the condition of the patient begins to exhibit many of the phenomena seen in the severe grades of experimental dioxidation: the respiratory rate goes up; the blood pressure tends to fall; the pulse rate increases; and mental anxiety, confusion, and delirium become accelerated. From the time when cyanosis becomes manifest, it may therefore be said that the patient's resistance is being subjected to a double attack; the vital tissues of the medullary centers, controlling respiration and circulation, the hard-worked muscles of respiration, the heart muscles are suffering not only from the toxins of the pneumonococcus but also from a deficient supply of oxygen and its consequence.

The laboratory methods for the detection of anoxemia are not feasible for general use. We must therefore depend upon such evidence as we can collect at the bedside. Cyanosis must be carefully looked for at each visit. It is best seen in the strong daylight and is apt to be the most striking change early; but the increasing leaden blue of the finger tips and eventually of the whole face and dependent portions of the trunk indicate the most advanced grades of anoxemia. Of course, where manifest heart failure is present, as in some elderly patients, some of the cyanosis may be attributable to venous congestion; and in occasional very toxic patients towards the end there is a cyanotic blotchiness of skin of the trunk, as in any case of virulent sepsis, which is caused by loss of vasomotor control with stasis in dilated skin vessels. Neither this cardiac nor this vasomotor form of cyanosis is due to general anoxemia. They play, however, an occasional part in the cyanosis of pneumonia. It will be to the interest of the patient to make the rule of treating cyanosis in this disease as indicating lack of oxygen.

The rate of respiration also furnishes information of value as to the degree of disturbance of the respiratory exchange in the lungs. This, however, is an attempt at compensation. If by means of this accelerated rate the necessary gas exchange is effected, then serious anoxemia with cyanosis will not develop; but if the increased rate is ineffective, cyanosis will appear in spite of it. It is important to note that when such a failure of compensation has occurred the increasing of the anoxemia is not necessarily by any further proportionate deepening of the cyanosis. A patient may have a respiratory rate of forty per minute and be free of cyanosis, and a few days later, with the same respiration rate, may be deeply cyanotic. The respiration rate is, therefore, not of as much value as a measure of anoxemia as it is of value as a warning of increasing anoxemia. When patients' respirations are under thirty we may feel that no serious call is being made upon the compensary mechanism; but if the rate of respiration is steadily rising, we may conclude that there is increasing interference with gas exchange, and if the rate, in adult, surpasses forty, even though cyanosis be not yet present, we may infer that it is eminent. Such high rates, moreover, cannot be maintained over many days because they exhaust the patient.

Before discussing the treatment of anoxemia in lobar pneumonia it will be well to say a word about the causes.

As in all febrile diseases, metabolism is elevated; there is increased oxygen need in proportion to fever. I saw in clinical diagnosis laboratory methods, by Todd, that the increase metabolism is estimated 7.2 per cent, for each degree of fever, so a case of pneumonia with temperature of 104 degrees will need 38 per cent more oxygen per minute than a normal person.

The significant fraction of lung tissue is consolidated and not severe for gas exchange. The importance of this handicap will depend, of course, upon the extent of the pneumonia process.

The unconsolidated portion of the lung is

thought by some to be less efficient in gas exchange than normal because of moisture, toxic damage to alveolar epithelium. There is no real proof for this theory; however, there may be some.

The type of compensatory breathing which develops in pneumonia is abnormal and less effectual in creating the alveoli of the lungs. This probably is a very important factor in the production of anoxemia. Compensatory breathing to increase gas exchange in the lungs, and to be effectual, must bring fresh outside air as close to alveoli as possible and replace it as rapidly as possible. This demand is usually met by increased depth of breathing and by increased rate of breathing. In pneumonia the rate is rapid but very shallow. External factors to this disease may be the cause of some of the shallowness of the breathing. Gas extension, in the bowels, obesity, emphysema with an ankylosed thoracic cage may prevent full costal excursion. Again pain in pleurisy often produces shallow breathing. But the same type of breathing is often seen when none of these conditions are present to explain it. There is as yet no proof as to the cause of this abnormality.

The pneumonococcus toxin can scarcely be said to have any specific action on the respiratory center since such a massive infection as pneumonococcus peritonitis has no characteristic respiratory effects.

In summing up, the anoxemia of lobar pneumonia is caused by greatly increased oxygen demands:

A—The air in room should be as fresh as possible; cold air is grateful to the patient, and quiets the breathing.

B—Try the patient in various positions to make him comfortable.

C—Keep the bowels open from the start to prevent abdominal distension.

D—Avoid plasters, or heavy jackets; light mustard poultices are beneficial.

E—By all means use the pneumonococcus serum in all types. I have found it very effective, though we are advised it will do no good except in Type I. You will save time and do no harm to use it in all cases.

F—I sometimes use morphine to quiet respiration; also the use of oxygen will be very effective in cases of cyanosis.

In pneumonia, as in all febrile diseases, there is an increasing demand upon the circulation. There is an active demand for transporting oxygen and carbon dioxide, and secondly, there is more heat to be carried from the center to the periphery of the body.

In studying patients during the course of lobar pneumonia there is much to be learned from clinical symptoms and signs. An analysis of the significance of these symptoms and signs has been briefly presented.

SYPHILIS OF THE STOMACH*

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In recent years the proof that syphilitic lesions may produce marked anatomical and functional changes in the stomach, has been firmly established.

In 1922, spirocheta pallida were demonstrated by McNee in an ulcerated area of the stomach. The histopathological studies by Chiari, Fraenkel, Warthin and others have lent further evidence that syphilis of the stomach is not a rare condition. The therapeutic evidence is attested by many cured cases cited by Eusterman and LeWald.

There are a variety of lesions having their origin in the submucosa nodulo-ulcerative, gummatous and diffuse fibrosis. There is found perivascular infiltration, with plasma cells, lymphocytes, and obliterative endarteritis.

The diagnosis of gastric syphilis rests upon roentgenological and clinical data, and the response to treatment.

The roentgen findings are briefly as follows:

(1) The appearance may be similar to that found in carcinoma but the lesions are usually more extensive and smoother in outline than in cancer.

(2) Linitis plastica or "leather bottle stomach."

(3) Deformity involving midportion, producing a dumb-bell like appearance.

(4) Diminished size of stomach.

The clinical and diagnostic aspects may be summarized as follows:

(1) Aclorhydria is present in the majority of cases; indeed, in a higher percentage than in carcinoma.

(2) The Wassermann reaction of the blood serum is positive in about ninety per cent.

(3) The average age of reported cases is about

*Read before Dade County Medical Society, Miami, January, 1933.



Upper figure shows appearance of stomach previous to treatment; lower figure, appearance after three months of antiluetic treatment.

thirty-six years—which is less than in ulcer or cancer.

(4) The course is progressive and the history of gastric symptoms is not intermittent or periodic as in ulcer.

(5) A palpable mass is less frequently found than in cancer.

(6) The syphilis may be hereditary or acquired.

(7) The symptoms are:

(a) Epigastric pain or discomfort which quickly follows eating.

(b) Vomiting is often present.

(c) Starvation—due to the fact that patients partake of liquid nourishment and in small amounts.

It may be said that syphilis of the stomach presents no unique symptoms, but that the symptomatology is conditioned entirely by the anatomical changes produced and thus other gastric diseases are imitated.

The distinctions between this entity and cancer, and benign ulcer would depend upon several points:

(1) Filling defect is less frequently associated with a palpable mass than in cancer, (20% versus 60%).

(2) The niche, accessory pocket or incisura, found in simple ulcer are absent. What may appear as a niche really does not project beyond the limits of the gastric lumen.

(3) The history is apt to be longer than in cancer patients.

(4) Bleeding is unusual and its absence is probably explained by the associated obliterative endarteritis.

(5) There is absent the cachexia found in carcinoma showing gastric involvement of an equal extent as shown by the X-ray.

(6) Favorable results following antiluetic treatment add further evidence.

An illustrative case came under my observation last September (1932). The following is a resume of the history:

A negress, twenty-five years old, stated that five months previously she began to have sharp burning pain in the epigastrium, which followed the ingestion of food of any type. Pain lasted until relieved by vomiting, or taking "soda." Later the pain increased in intensity, and she was unable to retain anything but milk. She had lost considerable weight. No previous similar attacks. There had been three pregnancies, five, seven, and nine months—all still-births.

Physical examination: Patient was undernourished, and appeared to be in acute distress.

Chest: Heart and lungs apparently normal.

Abdomen showed: Striae of pregnancy. Epigastric tenderness on pressure. A mass the size of a lemon felt in the epigastrium. No other masses or viscera felt. Slight anterior cervical lymphadenopathy.

The gastric contents after test meal, showed no free hydrochloric acid. Total acids twelve.

Blood Kahn 3 plus.

X-ray report on September 8th was as follows: Examination of the gastro-intestinal tract show a stomach which appeared to be normal in the vertical portion, but in the pyloric portion showed extensive defects which were typical of malignancy involving both the lesser and greater curvatures and causing a certain amount of dilatation in that portion of the stomach above the defect. The duodenal cap was fairly smooth and rather elongated.

At six hours there was a large residue in the stomach which still showed the same defects typical of a new growth.

Diagnosis: Probable malignancy; possibly, gastric syphilis.

Antiluetic treatment consisting of neoarsphenamine, potassium iodide, and bismuth was given. The vomiting ceased entirely within three days. Pain stopped in two or three weeks. In two months the mass which was felt in the epigastrium was no longer palpable. The patient has for the past three months been without gastric symptoms and states that she feels perfectly well. Her weight has increased from eighty-eight and one-half pounds to one hundred and seven pounds.

The last X-ray examination of the stomach shows that marked changes have occurred. At present the stomach outline is smooth. The filling defects have gradually disappeared. (See illustration.) Gastric retention at six hours is now absent.

Syphilis in a patient with a gastric lesion should be regarded as causal and only be considered as casual until so proven.

THE CONVULSIVE SYNDROME AND DEHYDRATION*

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Introduction

The following paper was not prepared as a discussion on the diagnosis and differential features of the convulsive syndrome. But it must be stated here that each case presenting involuntary muscular movements, be they slight or severe, local or general, should not be dismissed lightly with a meagre explanation of "epilepsy" or "epileptoid attack," but should be considered as a syndrome and a careful history, careful physical examination coupled with laboratory procedures should be done. The practice of medicine today would not be satisfied to find sugar in the urine of a patient and say to the patient "you have sugar in your urine so just don't eat so many sweets." Yet in many cases that is what is being done in regard to convulsive seizures. They are just considered "epilepsy" and a prescription of bromides is given. Convulsions are just as much a danger signal as is glycosuria.

In the following it will be my attempt to bring up to date certain clinical and experimental observations on the convulsive syndrome.

Recurrent fits and attacks of unconsciousness for many centuries have been thought of in the light of constituting a disease entity—"The Sacred Disease" or "Epilepsy." In recent years, with increasing knowledge of pathology, combined with experimental and clinical facts, a new view point has been taken by many. The fact that pathological conditions of various types may cause quite similar manifestations has caused a recent attitude of looking upon the convulsions and attacks of unconsciousness as symptoms of some fundamental disorder. The realization by all that clinical examinations before or after the epileptic seizure show practically no signs of involvement of the central nervous system seems to point against the presence of a disease entity. The view of Hughlings Jackson that a diseased motor cell could not produce increased activity as in convulsive responses is being confirmed by recent work. To quote Lennox and Cobb: "At the present time we are inclined to view the convulsion as a normal mass reaction of the motor level involved, to an appropriate stimulus, when inhibitory release is obtained. Thus it seems to be similar to the tendon reflex excepting in its higher complexity."

Especially interesting has been the recent work of Lennox Cobb, Fay, Winkleman, and Pendergrass, from both a metabolic and mechanical aspect on the causes and treatment of the symptom complex. The close association between disturbances in fluid volume relationships within the skull and its influence upon proper cerebral circulation has been considered an important disposing factor in the cycle of the convulsive seizure.

Hippocrates in 400 B. C. noted that the brains of those suffering from "The Sacred Disease" were unusually moist, and at the end of his essay on epilepsy makes the following prophecy: . . . "But whoever is acquainted with such a change in men and can render a man humid and dry, hot and cold, by regimen could also cure this disease without purification, and other illiberal practices of a like kind."

Gowers in 1881 was also struck by the moist brains of epileptics and believed that the fluid accumulations were the result of the convulsive seizures and not concerned with their occurrence.

Alexander in 1881 was another who was struck by the fluid about the brains of epileptics while operating on them, and in 1911 he devised an operation termed "fenestration" for draining this subarachnoid fluid, and reported three cases of epileptics treated in this way, with marked improvement for a while.

Kocker in 1893 believed the convulsive seizures were due to permanent or temporary increased tension of the cerebrospinal fluid and stated that the suddenness of changes of pressure and circulatory phenomena within the skull caused irritation of the pathologically sensitive cortex.

Dandy, in 1923, 1925, and 1927, discussed the frequency with which amounts of subarachnoid fluid have been demonstrated on the epileptic at operation, and he expressed himself as believing that the fluid increase was due to the filling in of spaces left by an unexplained atrophy, and in an article in 1923 stated: "It is mainly at operation that dilation of the subarachnoid spaces is demonstrable, . . . there is hardly anything more striking than the collections of fluid which covers the surface of the brain of the epileptic. They stand out almost as sharply as tumors on the surface of the brain. Instead of the normal convolutions separated by narrow sulci containing a small amount of clear fluid one sees accumula-

*Read before the Duval County Medical Society, Jacksonville, February, 1932.

tions of fluid completely covering areas of the brain to such an extent that the underlying cortex and its vessels are entirely invisible. Eliminating the focal lesions of known origin such as healed infections, traumatic, vascular defects, etc., most of these brains show the maximum amount of fluid over the region of the motor cortex. There is less over the occipital and frontal lobe."

In 1923 Foster Kennedy described the appearance of the brain which he witnessed at operation, during a convulsion as of sudden blanching followed by a tremendous venous engorgement with protrusion of the brain beyond the level of the operative defect. This is quite interesting in view of the statement made by Hughlings Jackson in 1863 that the fundus was pale before a fit, but during the seizure the veins became large and dark.

In 1926 Elsberg and Pike produced intracranial pressure by the introduction of vaseline between the dura and the skull in a quantity large enough to give a distinct mass. Following this it was noted that there was a convulsive susceptibility to smaller doses of absinthe than was required for the normal. Likewise after introducing distilled water intravenously (the effect of raising intracranial fluids) a convulsion was produced more easily than if a hypertonic solution was injected, with the subsequent use of absinthe and at that time those authors made the statement: "It may be that benefit from starvation in the treatment of some cases of epilepsy is due to some extent to decrease in intracranial pressure consequent upon the diminution of fluid intake."

Roundtree in 1926 introduced water by stomach tube into dogs in large quantities (50 c.c. per kilo body weight) every half hour. "Within four to eight hours there occurred in these animals nausea, vomiting, salivation, convulsions (generalized and of cortical type), stupor and coma. This procedure was associated with a rise in intracranial pressure and a distinct edema of the brain and vessels at necropsy."

Kubie in 1928 found that by introducing large quantities of fluid by stomach tube, that convulsions occurred and has also demonstrated marked changes in the brain and cord in those animals where no relief of pressure was undertaken. If, however, a puncture of the subarachnoidal space was made on the animal during the period of fluid administration and continuous free drainage of the spinal fluid permitted, no convulsive seizures resulted, and there was no alteration of brain bulk.

Temple Fay had occasion to explore or trephine seven cases during a period of status epilepticus and found greatly distended subarachnoid spaces, the opening of which yielded from one to three ounces of fluid under pressure and in all there was an immediate cessation of the attack coincident with the first release of fluid. He felt that this increased fluid within the subarachnoid spaces over the surface of the brain, confined within an almost closed box, the skull, acted as a hydraulic cast on the walls of the fluid pathways for cerebral fluid circulation and by this gradually produced in that area pressure atrophy of the brain. And in a recent personal communication he states the following: "The capillary meshwork thus compressed suffers periodic and prolonged states of anemia and anoxemia, which are followed by gradual loss of cell function and eventually actual death of the ganglion cells, themselves. Under the microscope the cortical gray matter is so characterized by a scattered falling out of ganglion cells, so that a selective atrophy is apparently present here as in other diseases, when survival is threatened by periods of low oxygenation and nutrition. Those cells which have already established important functions apparently survive as evidenced by the clinical manifestations, whereas, the undeveloped cells or those least important in coordinative mental and motor activity are lost, thus preventing progressive mental development, and augmenting deterioration.

ENCEPHALOGRAPHY

The encephalographic technic, which was introduced by Dr. Dandy in 1919 became employed in the studies of epilepsy. Pendergrass made a special study of this to bring out more than was formerly seen of the cortical fluid pathways. And he stated: "There was an increase in the size of the subarachnoid pathways in all of the epileptics that were studied by us. The first changes seemed to occur in the frontal region, then in the parietal region, and finally the basal cisternæ."

Temple Fay whose cases now run over two hundred says: "There has been noted a characteristic picture obtained by the roentgenogram in those patients showing convulsive seizures, . . . and in the early stages of the disease the areas of increased fluid collections are not marked, and are characterized by small areas situated at the vertex or in the fronto-parietal region . . . The areas of cortical atrophy as far as we can determine do not follow any vascular plan, but

do follow in exact outline the normal cerebrospinal fluid circulating field."

This supracortical increase of fluids noted years ago has now been confirmed by the encephalogram as well as by direct operative observation. Then the question naturally comes up of why is this fluid collected there. It is obviously one of three possibilities, one, an increase in production of fluid; two, a decrease in elimination of fluid; and three, a combination of disturbance of production and of elimination. The experimental work of Kubie has already been mentioned on the administration of hypotonic fluids by mouth, and it was largely from this work that the treatment of infectious diseases of the central nervous system by forcing fluids and continuous spinal drainage with the idea of washing out the system was begun. Another factor recently advanced by Gamble, Ross, and Tisdall, was the metabolic influence on fluid balance. They showed that fluid storage in the "interstitial" spaces is dependent upon fixed base sodium, and that with the loss of fixed base there is a rapid loss of water from this compartment of the body. It was further shown that on carbohydrate metabolism the body cells require approximately two-thirds more fluid for the process than they do on protein metabolism. He clearly shows the tendency of the body to store fluids when carbohydrates are plentiful in the diet, and fluid release when they are absent. Lusk, in his book on nutrition, has also made the statement: "A significant fact is that when the body changes from a carbohydrate diet to one of fat or protein there is a considerable loss of water."

Further observations from a metabolic point of view was made by Lennox and Cobb and reported in Medicine Monographs in 1928. They stated: "Acidosis tends to inhibit, and alkalosis to augment seizures," and showed that, (1) fasting or a diet rich in fat and protein, poor in carbohydrate, was followed by a definite decrease in seizures. (2) Acid or acid-forming salts, caused a decrease at first in the number of seizures, but later there could be an increase which they thought probably was due to an increase of Cl ion. (3) Exercising cut down on seizures. (4) Rebreathing and the administration of carbondioxide both cut down on seizures, and they showed that procedures which caused attacks in susceptible individuals do not cause them while inhaling air containing an increased amount of carbon-dioxide. They also felt that alkalosis tended to increase seizures, and this was tried by forced breathing when the blood became more alkaline, and by another method of ingestion of large amounts of alkali, each of which increased seizures.

Their second thesis was "an increased tension of oxygen in the tissue tends to inhibit and a decreased tension to augment." This was tried by having the patient rebreathe in a bell jar. As the oxygen decreased seizure resulted but in plenty of oxygen there was no seizure, and seizures were even prevented. To quote them: "The two conditions which have been mentioned, alkalosis and anoxemia on the one hand, and acidosis and increased oxygenation on the other, supplement each other. The chemistry of the blood is such that in the presence of acidosis oxygen is more readily given up by hemoglobin . . . and a decrease in carbon dioxide content of the blood augments the lack of oxygen. . . . The evidence so far gathered indicates that in certain epileptics subject to frequent seizures, these may be precipitated by oxygen lack and by alkalosis, however induced. Thorough oxygenation of tissue and acid base relation each plays an individual role—they complement each other; *i.e.*, acidosis lowers the oxygen dissociation curve and allows greater utilization of oxygen by the tissues; anoxemia results in relative alkalinity. Linked with these two factors is that of the water balance of the tissue. Acute acidosis is associated with dehydration because of the need for increased excretion of base, whereas acute alkalosis is accompanied by edema. Presumably, increased permeability of tissue is a correlary of edema."

Landis found that ". . . in the presence of anoxemia fluid passes through the capillary walls at four times the normal rate. Increasing the oxygen content of the capillaries tends to reverse the process and fluid returns to the vessels."

More recently McQuarre, Bartlett, et al., have done further work on the effects of diet and to briefly summarize their work it may be stated that they found a high carbohydrate diet favors retention of water, while a high protein, a high dextrose, or a high fat-acid ash favors elimination. They also believe that fluid balance was inseparably bound with the mineral content of the food and of the blood. The difference in the effect of the high carbohydrate diet and dextrose diet lies in the fact that the carbohydrate diets have a high mineral content and a dextrose a low mineral content. They came to the conclusion

that the degree of dehydration depends upon the mineral balance, the diets containing the least mineral and the least water being the most effective. It was thought that dehydration was not the only factor for if it was protein diets should have the best effects for it causes the most marked excretion of fluid. At times, however, it is found that high protein diet is ineffective and they offered as an explanation the possibility of the high mineral content of the protein diet. Hamilton, in a discussion of this, felt that if one method of dehydration is ineffective another should be tried. It was pretty conclusively shown that "a negative water balance, no matter how produced, was usually accompanied by a negative sodium and chlorine balance, and by the cessation of seizures, in subjects with severe attacks of epilepsy."

McQuarrie did another piece of interesting work by taking nine children with mild epilepsy and an equal number of non-epileptics to whom he administered water and empoules of pitressin. He says that all but one of the former had convulsions within 15 to 36 hours whereas none of the latter had seizures, although their increase in weight, owing to water retention, was as great or greater than that of the children with epilepsy. This procedure is therefore tentatively proposed by him as a diagnostic test for epilepsy in questionable cases.

Temple Fay feels then that the supracortical edema acts as a predisposing factor and that it

Condition Which May Tend To		
Prevent Seizures		Precipitate Seizures
Rich	Oxygen Supply	Poor
Decreased	Transudation of Fluids	Increased
Acidosis	Blood Reaction	Alkalosis
(1) Fasting (2) Diet (3) Acids (4) Carbon dioxide		(1) Hypernea (2) Alkali
Dehydration	Fluid Balance	Edema
(1) Spinal Drainage (2) I. V. Hypertonic Sol (3) Saline Catharsis		(1) Forced fluids (2) Hypotonic
Decreased	Intracranial Pressure	Increased

Modified after Lennox and Cobb. Medicine, 1928, VII, 105-290.

seems reasonable to accept a disturbance of circulatory function occurring just prior to an atmust precede all these changes to make effective at one time in the epileptic and ineffectual at another. That the hydration factor is the variable seems evident from our studies. . . . It is only in the hydrated states that the patient dies in tack as the precipitating factor. And to quote: ". . . The fact remains that a prepared state status or after prolonged convulsions. There seems to be much clinical evidence to favor the view that the petit mal and syncopal attacks which frequently shade into one another and later introduce the tonic and clonic phase of grand mal, if the condition progresses has a vascular disturbance as a precipitating factor."

PATHOLOGY

It is generally accepted that the pachonion bodies are the chief points of exit for the cerebrospinal fluid, and Winkleman has recently reported on his studies of the brains of quite a number of cases covering the convulsive state, and found that 80% of these brains showed acquired disturbances in the cerebrospinal circulating mechanism. This was thought to be responsible for the increased amounts of cerebrospinal fluid present over the cortical surfaces. Some work also by Swift showed that there were many cases found that had congenital and obstructive lesions of the lateral sinus interfering with the proper drainage. So that this anatomical and mechanical obstruction to venous drainage of the cortex were factors favoring cerebral hydration, and the hypertensive group of patients with high diastolic and venous pressures, or cardiac decompensation fall into possible drainage deficiencies and are characterized occasionally by convulsive seizures. The striking absence or great infrequency of convulsive seizures in the wasting diseases such as diabetes, tuberculosis, carcinomas, and other malignancies without complicating cerebral metastasis has been pointed out. Joslin states that in 5,091 cases of diabetes he has not had a case of epilepsy.

Dr. Walter Freeman, chairman of the committee on nervous and mental disease, in his address before the section said: "It is a significant fact that epilepsy and diabetes are never seen in the same individual, although it is not unknown to have convulsions in a diabetic and glycosuria in an epileptic patient. Excessive dehydration may lead to convulsive seizures and violent muscular movements to glycosuria, but as far as water balance is concerned epilepsy and diabetes are as much polar opposites as are hyperthyroidism and myxedema."

Another observer is quoted recently as saying that ". . . in over 2,000 histories that he examined, all the babies that acquired epilepsy later were the products of a difficult labor in which the brain was probably injured. He also looked into some thousand histories of babies born the Cesarian way without a single case of epilepsy in which the Cesarian section was performed early before the baby's head was all misshapen."

TREATMENT

The ketogenic diet which recently came into use in the treatment of epilepsy was started on the hypothesis to offset the waves of alkalosis said to precede a seizure by Jarloew. Wilder attributed the change to the anesthetic action of the acetone bodies, particularly the aceto-acetic acid.

Helmholtz and Keith in reporting on eight years' experience with the ketogenic diet stated, that after eliminating various types and those of poor cooperation, thirty per cent of the patients were free from their convulsive seizures, and seventy per cent were not free, and go on to say about dehydration: "It had been our impression that, although dehydration may be a factor in the control of convulsions it is not the only factor. It has been shown that dehydration has little, if any effect on the seizures of petit mal in epilepsy. The diet on the other hand has a definite influence on attacks of petit mal. Some of our most striking results have been in this type of case."

Fay says that "in the early stages of dehydration in our patients it has been a striking thing to note that when only grand mal seizures has been present for several years the first alteration of the attacks showed itself in the reappearance of the petit mal phase. The patients falling unconscious with few or no clonic movements gradually reach the stage when they do not fall." He quoted Bauer and says that Bauer had tried both the ketogenic and dehydration procedures on a series of 27 children, and that with the ketogenic method 35% showed improvement, but when placed on dehydration the same group over a period of one year showed almost 100% symptomatic relief from attacks. In a recent personal communication from Temple Fay he says: "As a longer period of time has elapsed, and greater number of cases have been studied, the percentage rate in a recent survey now indicates that 65% of the cases have been definitely improved; 13% attack free; 11% total failures, and the remainder non-cooperative. These figures represent the utilization of every means at our disposal to corrector influence the factors surrounding the patient outside of the walls of an institution. It is important to note that a true ketogenic diet has not been employed in this series, other than in the modified form used for the purposes of dehydration. A distinct improvement in mental acuity has been noted in almost every case where proper balance and cooperation have been maintained. This has been definitely present, even in those cases where the seizures were not materially influenced by the method of treatment. In the patients who have carried out the method during the past five years there has been but one instance of progressive mental deterioration; the others have improved, or the mental retardation has remained stationary, so that the clinical evidence would seem to support our belief that the pressure mechanism responsible for cortical atrophy and subsequent mental deterioration, if properly controlled, can preserve at least this important factor for the individual, leaving the convulsive mechanism to be treated as a separate entity."

He also calls attention to the fact that after following these cases for quite some time that, "in spite of the low urine output there have been no signs of renal irritation, or evidence of casts or albumin."

So then referring back to the statement made by Hippocrates, Lennox and Cobb give their modern interpretation of it as follows: "Whoever is acquainted with physiology and can render a man acidotic, dehydrated, and fully oxygenated could also repress this disease without minding purification of narcistic personalities, ritualistic empirical diets and all other illiberal practices of a like kind."

SUMMARY AND CONCLUSIONS

Epilepsy should probably be thought of as a "symptom complex" rather than a disease entity, and therefore it is very essential that a complete history, a careful physical examination with laboratory studies should be made on each patient presenting himself with convulsive seizures, with the attempt to find the cause.

Pathological studies on many patients having this trouble have demonstrated definite involvement and interference of the cerebrospinal fluid pathways and circulation, causing definite cortical atrophy, and the improvement of these conditions bringing about definite relief of symptoms.

Dehydration seems to be an *additional* weapon to use against this condition. Statistical studies at the present time point to this method as being very efficient in the relief of the convulsive state, as well as making the outlook for the mental side of the patient more promising, and it is here that the prevention of mental deterioration is paramount.

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THE PRACTITIONER'S PART IN DIPHTHERIA CONTROL*

F. A. Brink, M.D.,
Jacksonville.

In discussing the control of diphtheria before a group of practitioners it seems fair to assume that doctors are as much interested as anyone else in the prevention of unnecessary sickness and death. When quarantine or isolation was the only measure at our disposal for the prevention of diphtheria, disease was hampered but little and the number of cases recognized and unrecognized was very much greater than at the present time. The reduction in the number of deaths by the use of antitoxin has been thoroughly discussed and needs only passing mention here.

The Schick test affords us a ready means of determining whether or not the child is likely to contract diphtheria if exposed to the infection. Up to very recently it has been necessary to furnish the Schick test toxin in concentrated form and accompanied by a separate container of diluting fluid. After dilution the preparation is not very stable and should not be used after the day on which the dilution is made. For this reason it has been troublesome and expensive to administer the test in private practice. Ten tests is the smallest number that it is practical to put up in a single package and the 50-test package is more satisfactory. Therefore, the administration of the Schick test has remained largely in the hands of public health workers who have been able to organize large groups or apply the test to children already in groups such as school children.

With the recent advent of a stable diluted toxin it now becomes practicable for the private physician to administer the test in his office. It should be borne in mind that both preparations should be kept in refrigeration as much as possible when not in use; otherwise, dependable results cannot be expected and children supposed to be Schick negative will be having diphtheria.

In our field work it is the policy to Schick test all school children before proceeding with immunization except in school groups so small that the necessary additional visit does not seem warranted. Theoretically, it would seem to be the right of every child to have the Schick test before receiving the immunizing injections, but it has not

*Read before Duval County Medical Society, Jacksonville, March, 1932.

always been feasible to carry out this idea. It is also desirable that from 3 to 6 months after receiving the immunizing injections a child should be re-tested in order to ascertain whether or not he is among the 5 to 15 per cent who fail to develop immunity. This re-test is usually administered about 6 months after the injections.

The question of when to immunize a child has been discussed a great deal. Most authorities agree that when the baby is 6 months old there is danger of contracting diphtheria and dying from the disease and that such children respond very well to the injections by developing active immunity. There is also the advantage that younger children have very little local or general reaction from the injections.

Because of the fact that there is considerable difficulty in getting children gathered together in groups for testing and immunizing before they reach school age, it seems to be largely the province of the practitioners to give protection to the children in the earlier years of life. There is, however, a much more convincing argument for early immunization and that is the fact that of all diphtheria deaths 60 to 75 per cent of the victims are under 5 years of age. Health workers generally are willing and eager that the practitioners administer the toxin-antitoxin or toxoid very early in the life of the individual. The Schick test may then well be administered to children as they enter school and those that react may then be re-inoculated. The family physician probably sees the babies and pre-school children much more frequently than he sees them after they enter school. We look upon this as his opportunity and logical field of endeavor to get the younger children immunized.

Prior to the development of the Schick test there was much doubt as to the reason why many individuals exposed to diphtheria did not contract the disease. We now believe that immunity develops naturally as age increases. This is probably due to repeated exposure to infections too small to produce disease or to attacks of the disease so mild as to go unrecognized.

Among children of the pre-school age there may be only 50 or 75 per cent immune. Among the school age groups we usually find 80 or 90 per cent immune.

When the toxin-antitoxin mixture was first used the dosage was 3L plus. This was later reduced to 2L plus and we now find that 1/10L plus produces practically the same immunity previously obtained by the larger doses. Consequently we get a much smaller number of local and general reactions and the procedure is more acceptable to the general public.

Because of the possible danger of sensitization to subsequent doses of diphtheria or other antitoxin contained in horse serum it has been deemed advisable to use goat or sheep serum in the manufacture of the antitoxin used in this mixture. Although the danger from sensitization may have been over-estimated there have been a number of cases of serum sickness and the change to sheep serum seems wholly justified. In four instances serious consequences have followed the efforts to immunize children against diphtheria. The first was due to the use of an over toxic preparation; the second and third were due to the use of a diluted toxin for the toxin-antitoxin mixture. The fourth was due to the use of a toxin-antitoxin mixture without antiseptic. The mixture became contaminated with a virulent staphylococcus.

During the last few years a detoxified toxin has been prepared and is coming into general use. This is known as toxoid. It is prepared by holding the diphtheria toxin for several weeks at incubator temperature in the presence of a small amount of commercial formalin. The dose of this product is 1 c.c. It has been found that two doses given 30 days apart will immunize a slightly higher percentage of children than will the usual three doses of toxin-antitoxin. If three doses of toxoid are given the immunity develops in 95% or more of the children injected. In small children up to 6 or 8 years of age the reaction from toxoid is negligible. In older children and adults it may be unpleasant but not dangerous. A small intradermal injection of diluted toxoid may be given to detect individuals who are sensitive to the usual dose. These may be immunized with toxin-antitoxin or with smaller doses of toxoid. Toxin-antitoxin and toxoid must be kept in refrigeration to preserve their potency.

Pediatricians are making it a practice to call the attention of parents to the desirability of having their children immunized early in life and

there seems no logical or ethical objection to this practice. The general practitioners may well emulate the example of the pediatrician.

There is one other preparation used to immunize and that is a toxoid lanolin mixture known as Lowenstein's ointment. A dram of this may be well rubbed into the skin 4 or 5 times at weekly intervals. It is more troublesome and less effective than the other preparations but may be given by a nurse and is acceptible to some who object to the use of the needle.

Positive and definite results may be expected from the immunizing procedures. After a child has become Schick negative there is practically no danger of contracting diphtheria. The death rate among such children is almost zero. The general death rate from diphtheria in Florida has fallen appreciably since the immunizing program was put into effect notwithstanding the fact that most of the work has been done in the school age group.

Since there are still many susceptible children the practice of isolating cases and carriers must be maintained and the individuals may be released only after two consecutive nose and throat specimens have been examined and no diphtheria organisms found. It is just as essential to isolate a carrier as to isolate a patient unless a test has been made and the carrier's organisms proven non-virulent. Our practice of culturing contacts and school groups has seemed to have definite influence in preventing the spread of diphtheria in communities. Frequently in culturing large groups we find from 1 to 4 per cent are carriers. Many of these are very transient and prove negative on the first and second reculture after an interval of only a few days; others, a very small per cent, will persist for weeks and months after an attack or without any history of an attack. The use of local antiseptics in these cases is permissible but seems to be of little value, if any, and the removal of the tonsils seems to be the choice of procedure. We find that carriers who persist for more than a few weeks have tonsils with deep crypts. They are often considerably enlarged and should probably be removed regardless of the carrier state. The X-ray has been used with apparent success. Diphtheria antitoxin administered to a carrier is entirely worthless. If the individual were not already immune he would have become a patient instead of a carrier.

ACUTE OTITIS MEDIA*

WM. BULLARD JORDAN, M.D.,
Ocala.

In writing about a subject which has been so widely covered by otologists, it is hard to find any original thoughts to express. However, I will endeavor to discuss some of the more important phases of the disease that might be of interest to the general practitioner.

Acute otitis media is one of the more common diseases, especially in children, and of all the acute diseases there is none in which it is more important to make an early diagnosis, for it is the neglected cases in which we have the most serious complications.

Acute otitis media is an advanced stage of an infection that begins in the rhinopharynx and travels by way of the eustachian tube to the middle ear. Not only the inflammation itself may extend into the middle ear but pus may be forced into the cavity by vigorous blowing of the nose. Briefly, the cases may be enumerated as follows:

Extension of an inflammation via the eustachian tube in influenza and colds is frequent.

The acute exanthemata: Measles and scarlet fever are the most common.

Influenza and acute rhinitis are the most frequent causes, especially in children. It seems that the resistance in the tube is less in children, as the bony canal is not well formed until later in life.

About one case in seven with measles may be expected to have otitis. Gardner found in a series of 1,331 cases, 13.5% developed the disease.

Scarlet fever is frequently an exciting cause, usually giving us our most severe cases.

Pneumonia is very often complicated with otitis.

Improper blowing of the nose. Both nostrils should never be closed during the act of blowing the nose.

Swimming and diving, especially in pool or lake water, is a frequent cause.

Improper use of nasal sprays and douches.

Indiscriminate operations on the nose and too much packing after the operation. No nasal operation should be done when the patient has an acute rhinitis.

Injuries to the tympanic membrane and to the eustachian tube from improper catheterization,

*Read before the Marion County Medical Society, Ocala, Oct. 20, 1932. (Author died Jan. 17, 1933.)

also fracture of the skull, should be mentioned as rare causes.

Aspiration of infected material from the maternal passages at birth is a very important cause of latent otitis. The classical symptoms are not present. Otitis media is far from rare in the new born. It has been found repeatedly before the age of one month.

Other causes which might be mentioned are: tuberculosis and retropharyngeal abscesses.

The bacteriology of acute otitis media is such a broad subject that it will be impossible to go into details.

According to McNeal, pathologist at the Post-Graduate Medical School, N. Y., 90% of the cases are caused by streptococcus hemolyticus, 9% by pneumococcus and the other 1% by Pleiffer bacilli and staphylococcus; rarely by bacillus phocyaneus. Levine says that most cases are caused by influenza bacilli. Pneumococcus and streptococcus mucosus are the most virulent and are nearly always followed by mastoiditis, which requires operative interference.

Symptoms of acute otitis media vary very much. We will first discuss the usual symptoms. The patient usually gives a history of some upper respiratory infection. There may be a slight chill or frequently a convulsion in children; a feeling of fullness in the ear, with loss of hearing. This fullness gradually increases to a dull ache and finally an excruciating pain. Pain is worse at night. One patient expressed it very aptly. He said he had a "toothache" in his ear. This pain is usually confined to the ear at first, later radiating over the side of the face and over the mastoid. In some instances the pain is not in the ear. The temple, eye, or teeth may seem to be the site of the trouble.

In most cases the pressure of mucus which rapidly becomes pus is the cause of the pain. However, there may be severe pain with no pus or fluid at all. If the tympanic membrane is opened it is possible to hear the escape of air, and immediate relief of the pain is obtained.

Fever is a very indefinite symptom. In some of the most virulent infections the patient has very little or no advance in temperature. This occurs more often in adults. Children seem to be more prone to run moderate, if not high, temperatures, 102 degrees to 105 degrees.

If the pain is severe there is marked prostration. Children pull at the ear, or may have stiffness of the muscles in the back of the neck, leading to a suspicion of meningitis.

Very often in children there are no symptoms, which lead one to suspect middle ear infections. The child becomes suddenly ill with a high temperature, sweats, and chills. After ruling out every other disease it is surprising to find in an examination of the ears, the tympanic membrane bulging, either one or both. If a myringotomy is done the symptoms disappear like magic.

There are other symptoms that might be mentioned, but I will not take your time as the otoscopic appearance is the key to treatment of any acute middle ear infection. In making the examination, I use the head mirror, with a good clear electric light or, if electricity is not available, a good coal oil lamp will answer the purpose. I frequently use an electric otoscope, but after making thousands of examinations I am thoroughly convinced that mistakes are less likely to be made with the head mirror, as the otoscope magnifies too much. However, if one is not familiar with the use of a mirror, a clear vision may be obtained with the electric otoscope.

In the first few hours there will be only a marked reddening of the border of the membrane with a red streak coming down from the top over the handle of the malleus. In a few hours this congestion spreads over the whole membrane, becoming bright red. This redness may extend to the skin of the inner part of the external auditory canal. Soon this redness becomes dull and the membrane begins to bulge. If no incision is made it will rupture. The point which most frequently ruptures is above the center and posterior, to the handle of the malleus. After the drum ruptures a pulsation at the opening can be seen, and there is relief of pain.

The blood picture is very variable, however, there usually being an increase in the white count as in other acute infections.

DIAGNOSIS

Several conditions may cause pain and other symptoms leading one to suspect middle ear infections.

Furunculosis is the most frequent condition that has to be differentiated. In this condition there is marked tenderness of the auricle and early blocking of the external canal, also some swelling around the ear. In acute otitis there is no tenderness of the auricle, or swelling, except when there is involvement of the mastoid. The ear

seems blocked but it is not in the external auditory canal. In children under two years of age there is tenderness of the auricle in otitis media. However, otoscopic examinations will give the diagnosis.

Occasionally there is an otalgia from a bad tooth, especially from an impacted wisdom tooth. Inflamed tonsils may cause pain in the ear. These conditions can be diagnosed, however, by the appearance of the tympanic membrane.

PREVENTIVE AND ACTIVE TREATMENT

Preventive Treatment:

The proper treatment of acute catarrhal conditions of the upper respiratory tract is the removal of any obstruction to the nose and eustachian tube, deviated septum, etc., in the adult. Adenoids and tonsils should be removed in children if hypertrophied or infected.

Active Treatment:

Frequently, an attack can be aborted by rest in bed, through purgation and application of heat. This applies to the cases seen before pus has formed.

After twenty-four hours of expectant treatment, if there is no let-up in the symptoms, it becomes necessary to make a thorough incision of the tympanic membrane. In adults this can be done under local anesthesia.

Use equal parts of menthol, phenol, and cocaine. Moisten the tip of a pledget of cotton and apply directly to the membrane. This should be left in place twenty or thirty minutes. There will be a blanching of the membrane if the anesthesia is complete.

The incision should begin at the lower margin and follow the posterior wall around to the top. Very unsatisfactory drainage results from a puncture.

In children it is necessary to give a general anesthesia.

Ethyl chloride sprayed on an ordinary ether mask has proved very satisfactory, giving about one minute of complete anesthesia. Ether is used quite often, but is naturally contraindicated where there is an active respiratory infection.

The ear should be swabbed out and I prefer no dressing. Some insert a small gauze drain. However, I think it very unsatisfactory unless it is possible to change the drain often, which in most cases it is not. After the first twelve hours I begin irrigation, either with a very weak bichloride of mercury solution, or boric acid solution. These irrigations should be used every three hours, as the discharge is usually profuse and will have a tendency to block the drainage unless it is removed often.

A soft upper bulb or, better still, a catheter attached to a fountain syringe is most often used. The ear should be seen every twenty-four hours, at which time it should be thoroughly cleansed, care being taken to remove any obstruction from the incision. Usually I have neo-silvol, or argyrol instilled into the nose every four hours. This relieves any catarrhal condition in the nose and around the eustachian orifice. Supportive measures and usual treatment for an acute condition should be given along with the above.

Usually there is complete relief of pain in twenty-four hours after the membrane has been incised. In some cases, however, (fulminating type) there is no relief. Usually in this type of cases it is necessary to do an early mastoid. I have seen a few cases where a mastoidectomy became imperative within forty-eight to seventy-two hours, so it behooves us to watch our cases carefully.

The duration of the discharge varies from a few days to several weeks. The patient should be kept under constant observation, as it is by watching the amount and consistency of the discharge and the appearance of the membrane and external canal that a satisfactory prognosis can be given and the need for surgery realized.

During my service at the Bronx Eye and Ear Infirmary we had between one hundred and one hundred and twenty-five cases which required mastoidectomy. Any case in which the discharge had not begun to appear at the end of ten days or two weeks was watched very carefully, and was usually found to require a mastoidectomy.

The average lapse of time from the beginning of symptoms was three to four weeks before operation. This is a somewhat shorter period than most men wait. However, our results were better than the average. We had no brain or sinus complications. We had one death from pneumonia in a patient who had an acute nephritis.

Robins reports 828 cases of acute otitis media; 92% had complete recovery without mastoidectomy; 10% of the cases developed mastoiditis; in 180 cases the membrane ruptured of its own accord, and of this number one case in every four had to have mastoidectomy. In the other cases the tympanic membrane was incised and only one case in twenty came to mastoidectomy.

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 81, Jacksonville, Fla. Telephone 5-0577

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DRUGS OR DOPE

Those engaged in pharmacy and the practice of medicine feel that the indiscriminate use of the word "drug" where "narcotic" or "dope" should be used is a reflection on an honorable business and profession and tends to degrade it in the minds of many lay readers. As defined in the National Food and Drugs Act, a drug is an article used for the purpose of curing, mitigating, or preventing disease in man or other animal.

News writers and headline writers frequently refer to "drug" addicts, "drug" fiends, and "drug" raids when they mean narcotic (or "dope") addicts, narcotic fiends, and narcotic raids.

There is no objection on the part of the medical and pharmaceutical professions to the publication of the misdeeds or misadventures of "dope peddlers" or "dope addicts," but to describe them as "drug peddlers" or "drug addicts" does an injury, so it would be well for all editors to help discontinue the practice of using the word "drug" where the word "dope" or "narcotic" should be employed.

The practice is widespread in medical and pharmaceutical literature. Nearly every one having to do with such publications has been guilty of this misuse of the word "drug," even those of us who are seeking a discontinuance of the abuse.

If the editors of the medical journals would use the word "narcotic" or "dope" instead of "drug" in news items of raids or convictions, and in the columns advertising treatment for narcotic addicts, it would be a material aid in correcting an objectionable practice.

MEMBERSHIP DUES

Your attention is called to the record published on page 559 of this issue, concerning the amount of 1933 dues paid in by each component society. Seven societies have paid 100% of this year's dues: Broward, Columbia, Monroe, St. Lucie-Okeechobee-Indian River-Martin, Seminole, Sumter and Walton-Okaloosa. Our members who have not yet paid their state dues to the secretary of their county society are urged to do so at the earliest possible date. It is very expensive to write repeatedly to the secretaries of county medical societies concerning members who are delinquent in state dues. The officers of your Association at this time would like to impress upon each member the importance of forwarding, as quickly as possible, his dues through his county society and to thus relieve the treasury of unnecessary expense.

Beginning the first of next January the reduction in the amount of state dues will become effective but in the meantime your cooperation is solicited in completing the year 1933 so that we may begin the new year with a clean slate on a reduced basis.

RADIO BROADCASTS, 1932-1933

The following broadcasts were arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

AN UNFINISHED STORY—THE CONTROL OF TUBERCULOSIS*

SHERWOOD SMITH,
Jacksonville.

Knowledge that comes to one easily seldom arouses enthusiasm. However, the discovery of knowledge new to the discoverer always thrills. Most of the science we learn today represents the accumulation of discoveries painstakingly explored by pioneers; discoveries sometimes unsought for in the original objective. Possibly we can experience some of the thrills of these explorers by retraveling the trails.

The control of tuberculosis is an excellent example of a scientific trail not yet traveled to the end. From earliest times, even before the period of written history, we have evidence of this disease through certain identifying marks left on the bones of Egyptian mummies.

The writings of Hippocrates before the Christian Era in Greece, describe tuberculosis of the lungs or consumption in terms that are familiar to us today. He did not know the cause of tuberculosis, how it was acquired or what took place in the lung. His ideas of treatment were vague, but he recognized the value of good food and what we would term today good health habits.

During the Middle Ages not much knowledge was added to medical thought. Tuberculosis was generally regarded as hopeless. Nothing was yet known as to its cure or as to how it was spread. It was not until the seventeenth and eighteenth centuries that we have accurate descriptions of the changes that take place in the lung and an association of these changes with the disease. It is from the small nodules formed, or tubercles, that we have derived the name "tuberculosis."

In the latter part of the eighteenth century, a brilliant French physician, Laennec, stands out as a great discoverer. Among other discoveries he

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, December 4, 1932.

invented the stethoscope, and today we are familiar with this instrument which the physician uses to listen to what is taking place in the lung. Finally, the disease, to the control of which he contributed so much, claimed him as a victim.

Nearly a century later, another physician demonstrated the communicability of this disease from one person to another, and then Pasteur, often called the Father of Preventive Medicine, opened a new era in medical science through his discovery that germs are the cause of many diseases. This led to the discovery of the exact cause of tuberculosis by Robert Koch in 1882, at that time an obscure country physician in Germany. His work is one of the great scientific achievements in medicine.

A few years later, another scientist showed that the germs of tuberculosis are spread by the expectoration and cough of those who have the disease in an active form. In 1895, Roentgen, a German physician, by experimenting with a new form of electric light, accidentally discovered that certain rays penetrate opaque objects. From this developed our use of the X-ray, as he named it. It is considered essential to the diagnosis of tuberculosis in the early stages before there are any symptoms or physical signs.

There are two general types of tuberculosis germs which affect mankind, the human type and the bovine type. This was demonstrated by one of our own scientists, Dr. Theobald Smith. The eradication of tuberculosis from dairy herds and the increasing pasteurization of milk is making bovine tuberculosis less and less of a danger to mankind through these adequate control measures.

In the early part of this century, further knowledge has been discovered: first, that many persons are infected with the tuberculosis germs who never die of the disease and that infection can be measured by a simple test, devised by Robert Koch and later perfected by others. This is known as the tuberculin test. With the X-ray, it is our most valuable aid in detecting the beginning of the disease in children.

The program for the control of tuberculosis today is based on the prevention of massive doses of infection and on the building up of the health of the individual whether or not he be infected.

TREATMENT

The treatment of tuberculosis ran through much of the same cycle as the treatment of other diseases until our knowledge became exact as to its progress and cause. By the early part of the nineteenth century, in both England and Germany, institutions had been opened for the cure of tuberculosis. They both advocated rest, fresh air and to a certain extent, exercise. Rest is today the most important part of our treatment—rest for the whole individual or more intensive rest for the part of the body affected. Part of the lung itself can be rested through techniques familiar to the physician. Carlo Forlanini, an Italian, is usually given credit for this development.

The beginning of sanatorium treatment for tuberculous persons in this country was started by Dr. Edward L. Trudeau in 1885. The story of his life is an epic describing the work of one individual for the control of this disease. Today there are many institutions throughout the country, private, municipal, county and state. In Florida, there are eight counties which make this hospital provision, but one of our real public health needs is a state institution.

The treatment of tuberculosis of other parts of the body than the lung by sunlight has met with success. This work was inaugurated by a Swiss surgeon, Bollier, in 1903.

ORGANIZATION

For our earliest organized community efforts to control tuberculosis we turn to Sir Robert Philip in Edinburgh in 1807, and later Dr. Calmette in Lille, France, and Dr. Hermann Biggs in New York City. These men opened our first dispensaries for diagnosis and treatment. Dr. Hermann Biggs, Commissioner of Health of New York City in 1887, distributed the first educational pamphlet. In 1892, the first tuberculosis association was organized in Pennsylvania. Dr. Biggs also obtained the passage of a law compelling the reporting of all cases of tuberculosis.

Sir William Osler in Baltimore assigned two of his young women medical students to follow up tuberculosis cases in their homes to see that they were following the physician's instructions, thus starting the first tuberculosis nursing service.

The National Tuberculosis Association was organized in 1904 to carry on scientific studies for the prevention and cure of tuberculosis and other activities to arrive at that end. These activities, as their value has been demonstrated, have been turned over to official health departments as a part of their regular tax-supported program. We are all familiar with the work of this association through the annual Christmas seal sale which finances it.

A recent development is the institution for children who have the childhood type of tuberculosis and who come from homes where it is impossible to give an adequately supervised regime of rest and care. The first institution of this kind (prevention), was established in New Jersey in 1909.

Diagnostic and treatment technique are steadily being perfected and methods of control are becoming increasingly efficient. A Medical Research Committee was organized by the National Tuberculosis Association in 1920. The laboratories of some twenty universities or more and other institutions have been placed at the disposal of the association for its research work, and the staffs of these various institutions are giving their services in the hope that a specific cure may some day be found.

An index for the measure of control of a disease is the ratio of the number of deaths to a unit of population. The death rate from tuberculosis, then, is that number of persons dying from tuberculosis in any one year based upon an arbitrary unit of 100,000 persons. In the United States, the death rate has declined from a rate of 200 to a rate of approximately 75 in 1930. The approximate rate of decline from 1900 to 1910 was 20%, from 1910 to 1920, 25%, and from 1920 to 1930, 40%. The decrease in the deaths from tuberculosis has not been uniform throughout the different age groups. The greatest gain has been made in the group under five years of age. Part of the gain for this group is probably due to the increased protection of our milk supplies.

We know that tuberculosis apparently affects different races under similar conditions differently. To what extent different environments and different tribal and racial customs play a part in this cannot be accurately determined. The mortality rate for negroes is from 2½ to 3 times that for white persons. It is declining in approximately the same rate although at a higher level. As to occupational influence, we usually find the highest death rate from tuberculosis in the lowest income groups.

The states having the highest death rates from tuberculosis are those in which there is a large negro population and also that group of states in the southwest where there has been a large influx of tuberculous persons from other communities. Florida's rate is approximately that of the United States as a whole and one of the lowest for any state in the south.

As compared to the decline in the death rate from tuberculosis, we have an increase in heart disease, cerebral hemorrhage and cancer. It is interesting to note that deaths from these causes occur generally late in life, while tuberculosis reaches its peak in the industrial age group, from 15 to 45.

There is for all countries a close correlation between the decline in the general death rate and the tuberculosis death rate. This relationship tends to indicate the importance of environmental factors and the general state of health on tuberculosis mortality. In the later years of the World War, there was a tremendous increase in the death rate from tuberculosis in the Central European powers and the other nations which had suffered the most, in some cases the rate reaching over ten times the present figure for the United States.

It is gratifying to know that in this country, with individual finances at a low ebb, our tuberculosis death rate continues to decline. However, we cannot be too optimistic, for tuberculosis is usually a long chronic illness, the effect of which would not be shown in death rates for a few years to come. It is essential for the protection of all of us and to save the gains that have already been made that adequate community public health procedure be carried on so that those with tuberculosis and now financially unable to care for themselves will not be a danger to the whole community. Public health is community insurance, purchasable in the same way that individual insurance may be purchased, by paying a premium in order to receive protection.

In closing, I quote from Dr. Louis I. Dublin, past president of the American Public Health Association:

"It is my deliberate opinion that the control which we have gained over the causes of sickness and of premature death constitutes the most important and single advance by the American people in the last fifty years."

We are well on the trail to the control of tuberculosis as a public health problem.

"The greater the regard that physicians have for one another in a given community, the greater will be the public regard and esteem for our profession."

—James M. Anders.

CANCER AS A PROBLEM OF THE PUBLIC HEALTH*

GERRY R. HOLDEN, M.D.,
Jacksonville.

During the last few years cancer, in the various forms in which it affects the human body, has become a serious problem of public health. This is because the number of people who have cancer is apparently rapidly increasing in this country.

Whenever a person dies from any cause, the doctor must state on the death certificate the cause of death. From a study of all these death certificates the public health officials are able to find out what diseases are the most frequent causes of death and the relative order of their importance.

In 1900, tuberculosis, with a mortality rate of about 200 per 100,000 population, took first place among the causes of death in the United States, while cancer, with a mortality rate of 63, stood in sixth place. In 1929 tuberculosis had fallen to sixth place, with a mortality rate of 76, while cancer had risen to second place with a mortality rate of 96 per 100,000 population—an increase of 52 per cent for a 30-year period.

In Florida, vital statistics show an even more rapid rise in death rate. In 1917 the total deaths from cancer were 378, a rate of 41. In 1926 the rate had risen to 68, while in 1931 the total deaths were 1,072, a death rate of 71 per 100,000 population, an increase of about 70 per cent for a fourteen-year period.

These figures should not be interpreted as meaning that the actual number of cancer cases in existence has really increased at this rate. A number of factors must be considered before drawing final conclusions. Great improvement has taken place in the collection of these records. The great advances which have been made in medical education and the training of physicians have made the average doctor a much better diagnostician than he was some years ago. More cancer cases are recognized today. Moreover, due to improved conditions, we now have a larger proportion of our population of the "cancer age", middle life and beyond. This last factor applies especially to our own state, on account of the large numbers of middle aged who are included in our annual tourist population.

While these factors must account for some of the apparent increase in the number of cases, it seems impossible for them to account for all. It is generally conceded that, in spite of improved methods of diagnosis and treatment, and in spite of the efforts made to get cancer cases early, when they have a chance of being cured, cancer, both from the standpoint of numbers and of percentage, is actually increasing.

Cancer is one of the oldest known diseases. Undoubted cases of cancer are mentioned in the Bible. We are told that the Egyptians were familiar with it and that the earliest writings of India make mention of it. On down through the ages it has been known, recognized and dreaded.

It is not to be wondered at that there has gradually accumulated, during all these years, a vast number of erroneous and absurd ideas about it—ideas about its cause, its nature, its treatment, and its course. Many of these false conceptions, passed on to us from the ignorance of former years, are some of the greatest stumbling blocks in the control of cancer today.

The erroneous notion that cancer is a hereditary disease, that because a parent died of cancer the offspring will necessarily suffer from it, is widespread. This idea is wrong. While we do occasionally find families in which the repeated appearance of cancer in various generations seem to lend credence to this impression, such incidences are rare and by no means prove the case. Cancer is not a hereditary disease.

Much misery and mental distress are caused at times, both to patients and their families, by the beliefs that cancer is contagious, or that there is something degrading about it. Many patients hide the fact that they have cancer through feelings of shame.

The public mind should be disabused of both of these points. Cancer cannot be transmitted from person to person by any of the ordinary contacts of human life. Neither can any possible disgrace be attached to the cancer sufferer.

One of the most pernicious of these traditional fallacies is the idea that the treatment of cancer is always unsuccessful. How often do those doctors who are seeing a large number of cancer cases hear the awful dictum that, "There's no use doing anything. Cancer never can be cured." Many a cancer death is due to the delay caused by this erroneous notion.

Of course, it must be admitted at once that, with our present knowledge, cancer can be cured only if treated before a certain stage in its growth

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, December 17, 1932. (Delivered by Dr. H. C. Dozier, Ocala).

has been reached, although at the same time it is true that, even in advanced cases, much can often be done to mitigate suffering and even to prolong life.

Theoretically, every cancer can be cured if it can be recognized as cancer while it is still a local disease, before it has been carried from the place where it started to other parts of the body, provided that we can remove completely every portion of the original growth. If attempts to cure a cancer are unsuccessful, it simply means that one or both of these two conditions could not be fulfilled.

While it is true that today the majority of all cases of cancer come to the hospital with the disease so far advanced that it cannot be radically cured, it is also true that of those cases which are treated in the early stages of the disease the majority can be cured.

A few moments ago, I implied that the ultimate cause of cancer is unknown. That is true. We do not know why certain causes, certain stimuli, should make normal tissue cells change into those abnormal cells which we recognize as cancer cells. But if we do not know how these causes act, we do, at any rate, know what many of these causal factors are. Then by eradicating these causes before the cancer ever starts, we are actually preventing the appearance of cancer and are helping to cut down its death rate.

To illustrate: We often have cancers developing in parts of the body that have been the location of long continued chronic irritations and inflammations. This is so frequent that we consider such chronic irritations as predisposing these parts to the formation of cancer. Irritations of the tongue, or the inside of the cheeks, sometimes terminate in this way. These irritations may be caused by ill-fitting dentures, jagged or decayed teeth, etc. If, then, we relieve these conditions by attention to the teeth, by proper dental work, we are doing prophylactic work toward the reduction of the cancer mortality.

The field for this type of work is wide. Many different types of cancer may arise from this cause. Skin cancers frequently arise in some pre-existing skin irritation. For example, long continued exposure to the sun and weather sometimes brings on, especially in people of the blonde type, lesions which finally end in skin cancer. Such cancers may occur among outdoor workers, fishermen, farmers, truck-growers, etc., who habitually expose themselves without protection to the hot rays of the sun.

Cancers of the lip sometimes occur at the spot where a favorite pipe has irritated the mucous membrane for many years. The old clay pipe of our grandfather's days was a cause of cancer, as its rough stem had a peculiarly irritating effect on the delicate tissues of the lip.

In the genital tract of women chronic irritation is a potent factor. The majority of all cancers of the womb begin in an old tear of the neck of the womb which has been neglected and has become irritated. Also, we may have an irritation beginning in pre-existing growths, such as some types of moles, which turn these growths into cancerous processes.

Other irritations exist which are at times less easy to diagnose than those previously mentioned. A certain proportion of gastric ulcers become cancerous in their later stages. The same is true, but much less common, of some cases of chronic irritation of the gall-bladder and of the prostate gland.

Enough has been cited to point out the way by which preventive medicine can help in reducing cancer mortality by preventing the cancer from starting. Education of the public to a realization of the possible danger of such long-standing irritations is one of the important factors in preventive medicine.

A moment ago, mention was made of the fact that certain types of moles and other benign skin growths sometimes become malignant. This phenomenon is an illustration of another type of precancerous trouble. Certain pre-existing growths, originally not cancerous, for some reason or other, may later develop into cancer. Various skin growths fall into this category. So also do some tumors of the thyroid gland, prostatic growths, and certain uterine tumors. More frequently do we see cysts and tumors of the ovary, sometimes after many years of slow and innocent growth, become transformed into malignant tumors.

While it is true that the great majority of the various growths just mentioned do not become cancerous, yet a certain proportion do undergo such a malignant change. If this knowledge could be disseminated to the public so that the average man and woman could understand the possibilities and take proper measures for self-protection, an important step toward the reduction of cancer mortality would be taken.

Passing from the domain of preventive medi-

cine to that of actual treatment of these conditions, it is necessary to emphasize again the necessity for early diagnosis. Unless we can get the growth in its early stages, before it has become generalized, we cannot hope to cure it completely. In this lies the importance of a careful and thorough examination and an exact diagnosis in those cases which may be early cancer.

For thirty years or more various individuals and organizations have been endeavoring to impart to the public knowledge about cancer. It is slow work, oftentimes very discouraging. Nevertheless, much has been accomplished. Before this educational program was instituted the majority of all cases of cancers peculiar to women applied for examination only when the growth had become extensive and inoperable. Such a thing as a woman voluntarily coming to the doctor's office to be examined for cancer was practically unheard of.

Today the picture is very different. For women to come to the gynecologist's office with the question, "Have I got a cancer?" has now become an almost everyday occurrence. To be sure, the great majority have no cancer, but not all. Every now and then an early cancer of the breast or the uterus is discovered in this way and the woman is given a chance for life which she would not have had otherwise.

The American Society for the Control of Cancer is one of the most active of the organizations endeavoring to spread information on this subject to the public. The American Association for Cancer Research is interested in the scientific study of the disease. The American College of Surgeons, the United States Public Health Service, the Massachusetts and the New York State departments of health are a few of the other agencies which are studying these problems and are endeavoring in various ways to reduce the number of cases.

In conclusion, I wish to recapitulate the essential points which I feel that every person should know about cancer.

Any sore or ulcer which runs a chronic course and will not heal should be examined by a competent physician.

Chronic irritation or inflammations in any part of the body demand measures to relieve them. This is especially true in irritations about the mouth, tongue, lips and the inner side of the cheeks.

Chronic skin irritations should be relieved. Persons with delicate skins, especially of the blond type, should not permit long exposures, day after day, to the sun or wind without first properly protecting the skin.

Certain growths, which appear to be non-malignant, should at least have an examination before allowing them to remain, as they may develop into cancer. This is especially true of certain types of warts and moles.

Symptoms of rectal trouble should not be neglected. While a self-made diagnosis of "piles" may be correct, the symptoms may be those of rectal cancer.

Especially should the symptoms of cancer of the womb be emphasized. Because of the phenomenon of normal menstruation, women are so accustomed to vaginal bleeding that they do not realize how significant the appearance of any abnormal flow may be. It should be emphasized that this may be the first recognizable sign of either a malignant or a benign growth. Hemorrhage at the age when the change of life usually occurs is not a symptom of the change of life.

STATE NEWS ITEMS

Dr. J. Knox Simpson of Jacksonville was ordained and installed as a ruling elder of the Riverside Presbyterian Church, Sunday, May 28th. Dr. Simpson is president of the Duval County Medical Society.

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Dr. Albert H. Freeman of Ocala announces that Dr. Ralph E. Russell has become associated with him in the practice of ophthalmology and otorhinolaryngology. They occupy suite 30-34 of the Holder Block.

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Dr. Fred H. Albee of New York will, in the near future, establish a general hospital at Venice, Florida. The Parkview Hotel, a boom time resort, will be converted into the main hospital unit.

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Dr. Jack Halton announces the removal of his offices from Sarasota to the Citizens Bank Building, Tampa. Dr. Halton will confine his work to proctology.

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Dr. John D. Milton of Miami has returned from a convention trip, which included meetings in Hollywood, Havana, Cuba, and St. Petersburg.

Dr. Maurice E. Heck of Miami left early in June for Bushkill, Pennsylvania, where he will practice his profession during the summer months.

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Dr. and Mrs. F. B. Emeis of Jacksonville announce the birth of a son, Francis Bartow, Jr., May 27th.

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Dr. Ernest B. Milam of Jacksonville headed a delegation, representing Kiwanis Clubs in this state, which left for Los Angeles on June 19th to attend the international convention of Kiwanis.

JOSEPH P. ESCH

Dr. Joseph P. Esch, one of the notable figures in the civil life of Daytona Beach for 30 years, died at his home on May 9th, at the age of 84 years.

Dr. Esch was born in Kausen, Germany, in 1849 and came to America in 1865. He studied medicine with his father, Dr. John A. Esch, and received the degree of M.D. from Wooster University and the College of Medicine of Western Reserve University at Cleveland. After practicing his profession at Huron, Ohio, he began coming to Florida in 1893, and finally established his home here.

Dr. Esch was a direct descendent of the Knights of Esch, who participated in the First Crusade of the Middle Ages and who maintained a feudal castle that is still one of the landmarks of Luxemburg. He was an elder in the Presbyterian Church, a Mason, a consulting member of the Halifax District Hospital, member of the Volusia County Medical Society, the Florida Medical Association and the American Medical Association.

Dr. Esch is survived by his widow, two children, two grandchildren, and a brother, Dr. William J. Esch of Cleveland.

W. J. LEE

Dr. W. J. Lee of Panama City died very suddenly at his home, Saturday evening, April 22nd, at the age of 62 years.

Dr. Lee, who was a graduate of the Kentucky School of Medicine, class of 1893, came to Bay County about 25 years ago and during this entire period he was very active, both in the practice of his profession and in civic affairs. He was the first president of the old First National Bank of Panama City, a Mason, secretary of the Bay County Medical Society, a member of the Florida Medical Association and the American Medical Association.

Dr. Lee is survived by his wife, a son, Wayne E. Lee and a daughter, Louise.

Dr. A. G. Williams of Lakewood has just returned from a business trip to Oklahoma City.

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Dr. and Mrs. E. J. Melville of St. Petersburg recently sailed from Norfolk, Virginia, for Central Europe. They will spend some time at Vienna where Doctor Melville will do special work in the clinics. Dr. and Mrs. Melville expect to return to Florida about October 1st.

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An organization meeting of the alumni of Emory Medical School was held during the convention of the Association at Hollywood in May. Dr. L. M. Anderson of Lake City was elected president, Dr. H. L. Bryans, Pensacola, vice-president, and Dr. J. C. Pate of Tampa, secretary-treasurer.

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Dr. Jesse Newman McLane of Pensacola and Miss Marguerite Brittain Thompson of Tallahassee were married on May 4th at the home of the bride. Dr. and Mrs. McLane are at home to their friends at the Mirador Apartments, Pensacola.

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Dr. and Mrs. E. Sterling Nichol were recent visitors in Washington, D. C.

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Dr. W. J. Johnston of Sarasota was recently named assistant medical director of the Florida Medical Center at Venice, by Dr. Fred H. Albee, its founder. The Center will open about November 1st.

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An interesting and colorful program has been arranged for the Fifth International Medical Post-Graduate Course of the Tomarkin Foundation, Locarno, which is to be held at St. Moritz August 13th to 27th. The following special subjects will be dealt with in lectures: allergic diseases, diseases of the blood, free lecture field, climatology, rheumatism and arthritis and diseases of metabolism. A special excursion rate will be available. Further information may be secured from Mr. George Hoyt, A. R. Elliott Advertising, 53 Park Place, New York.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was held Friday evening, June 2nd, 8:30 p. m., at the Huntington Club Rooms. The following program was presented:

"Fracture of the Elbow Joint. Case Demonstrations," Arthur Weiland, Coral Gables.

"Fracture of the Carpal Scaphoid. Case Demonstration," F. A. Vogt, Miami.

"Abnormalities of the Vertebral Bodies," Gerard Raap, Miami.

Several resolutions have been proposed by the Committee on Economics of the Dade County Medical Society. Among others, this Committee favored the adoption by the society of a resolution recently passed by the Duval County Medical Society, making a charge of $5.00 for information required by insurance companies relative to the health of former or present patients. (See page 398, March, 1933, Journal). The committee also favored the passage of a resolution intended to stimulate the registration and balloting of members of the society at the local election.

DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held at 8:15 p.m., June 6th, at the Mayflower Hotel. The following symposium on pediatrics comprised the scientific program:

"Diet for 1933," Thomas E. Buckman, Jacksonville.

"Impetigo and Other Common Medical Problems of the New Born," William E. Ross, Jacksonville.

"Gastro Intestinal Problems in the New Born," Luther W. Holloway, Jacksonville.

To make their programs interesting and to the point, this Society requests all members who enter into the program to confine their discussions as follows:

1. Not over 10 or 15 minutes for each topic.
2. Give own personal experience to exclusion of culled material from the literature or text books.
3. Emphasize important points which may help the average practitioner in making a diagnosis or in carrying out proper treatment.
4. Important points in differential diagnosis.

ORANGE COUNTY MEDICAL SOCIETY

The regular May meeting of the Orange County Medical Society was held in the lounge of the Orange General Hospital, Wednesday evening, the 17th, with President Hewitt Johnston in the chair. Routine business was quickly dispatched and the balance of the evening was devoted to consideration of the proposed Constitution and By-Laws, prepared by a special committee consisting of Doctors Meredith Mallory, Frank Gray and Gaston Edwards. A few minor corrections and suggestions were made. Final action on the new Constitution and By-Laws was delayed until the June meeting of the society.

There was a brief discussion of the various bills of a medical nature which had been introduced by the Legislature. Disapproval was expressed of Bill No. 774, which would permit the practitioner of any healing art to use all hospitals supported by public funds and each member was requested to wire the senators and representatives of his county in this connection.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. and Mrs. T. F. Jackson of Dade City entertained the members of the Pasco-Hernando-Citrus County Medical Society with a picnic dinner, Thursday evening, May 18th, at Lake Iola Beach. After dinner, entertainment was furnished by a colored octet of Dade City. This was followed by the regular scientific meeting. A rising vote of thanks was extended to Dr. and Mrs. Jackson for the splendid entertainment.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society was recently again confronted with the problem of what action should be taken with reference to the examination of pre-school aged children. The Society agreed upon a minimum fee of $2.00 for each examination. Indigent cases will be taken care of by the Society, the amount collected to go into the treasury. Following is the very comprehensive letter addressed by the secretary of the Society to the president of the Parent-Teachers' Association of St. Petersburg:

"St. Petersburg, Fla.,
"May 11, 1933.

"Your letter directed to the Pinellas County Medical Society relative to the summer round-up

and examination of children of pre-school age has had the earnest consideration and thorough discussion by the membership of the Society, with concensus of opinion as follows: the Pinellas County Medical Society is very desirous of cooperating with the Parent-Teachers' Association of this county in the examination of children of pre-school age and is in full sympathy with the aims and purposes of your organization.

"Organized medicine as represented by the American Medical Association and its component State and County Units has adopted a minimum standard of examination for this work. The specified examination as outlined in the form of which you have copies cannot be done well in mass. We, as physicians, feel that these mere inspections have been so superficial that reliance has oftentimes unwisely been placed upon them to the detriment of the child.

"Therefore the Pinellas County Medical Society has unanimously decided upon the following method of procedure: that each child receive a blank (Hygeia form) which shall be taken to his own family physician who will make the examination. We understand that methods have been perfected by which you contact these children. When you have made every effort to have these children examined by their own family physician, we realize there will be those who will not be able to secure an examination for financial reasons. If you will furnish us with a list of these children we will be glad to enter into negotiations through our President to have them examined by the Society on such terms as may be determined.

"It is our hope that you will immediately notify the various P. T. A.'s throughout the county of our action so that the procedure may be uniform and that this work may be simplified.

SARASOTA COUNTY MEDICAL SOCIETY AND MANATEE COUNTY MEDICAL SOCIETY

An interesting, joint meeting of the Sarasota and Manatee County Medical Societies was held at the Whitfield Country Club, Sarasota, May 16th. Guests of the Society were: Drs. E. W. Bitzer, Joseph Taylor, Frank Metzger, and C. A. Andrews of Tampa and Dr. I. Clark Gary of Chicago. Dr. Bitzer presented a paper on "Treatment of Hypertension," which was liberally discussed. Dr. Jack Halton of Sarasota read a paper, illustrated by a number of slides, on "Treatment of Rectal Strictures."

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, Inc.

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Mrs S. E. Driskell
1410 Windsor Place
Jacksonville, Florida.

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SOCIAL EVENTS OF THE CONVENTION FOR THE AUXILIARY

Among the many courtesies extended the State Auxiliary during the recent convention of the Florida Medical Association, held in Hollywood, by the hostess Broward County Auxiliary, the social features will long remain most pleasantly in the hearts and minds of their fortunate guests.

The visiting ladies were showered with the most thoughtful attentions—the incoming and out-going officers of the State Auxiliary, together with the wife of the out-going president of the Medical Association being especially remembered and feted. Beautiful flowers were sent daily to the rooms of these ladies and other lovely social attentions were paid them.

The Cabana party, Tuesday afternoon, May 2nd, was the first event on the program for purely social enjoyment. Various sports had been planned for this occasion, chiefly the invigorating dip into the ocean. Dainty refreshments were served during the afternoon.

In the spacious lounge of the hotel Tuesday evening the visitors enjoyed interesting games of bridge, the prize, a lovely hand-made purse, going to Mrs. George I. Jones.

Wednesday noon the ladies were entertained at a beautifully appointed luncheon, followed by an enjoyable ocean voyage on board the U. S. S. Unalga.

The annual banquet and grand ball came off at 9 o'clock Wednesday evening, and the annual executive board luncheon was given Thursday noon.

In no way was this 1933 convention a grander success than it was in its many delightful social functions.

POLK COUNTY

The Woman's Auxiliary to the Polk County Medical Society held its first annual meeting at the Lake Region Hotel in Winter Haven, April 12, at 7:00 p. m.

After a delightful dinner the annual reports were given. Of especial interest was the loose-leaf note book kept by the publicity chairman, Mrs. Walter A. Weed of Lakeland.

Mrs. E. R. McMurray of Bartow, retiring president, made a splendid talk on Auxiliary work.

Delegates to the State meeting were elected as follows: Mrs. J. F. Wilson of Lakeland and Mrs. Stephen Gyland of Brewster, delegates, and Mrs. J. D. Griffin and Mrs. R. L. Cline of Lakeland, alternates.

An attendance chairman was appointed in each of the towns in Polk County as follows: Mrs. E. R. McMurray, Bartow; Mrs. Stephen Gyland, Brewster; Mrs. G. H. Carefoot, Ft. Meade; Mrs. W. W. Shafer, Haines City; Mrs. Walter A. Weed, Lakeland; Mrs. B. D. Epling, Lake Wales; Mrs. V. H. Ragsdale, Pierce; Mrs. F. E. Irons, Winter Haven.

Officers for the coming year were elected as follows:

Mrs. J. F. Wilson, Lakeland, president.
Mrs. F. E. Irons, Winter Haven, vice-president.
Mrs. V. H. Ragsdale, Pierce, secretary-treasurer.
Mrs. Walter A. Weed, Lakeland, publicity chairman.

Members present at the meeting were: Mrs. J. G. Gilchrist, Mrs. J. L. Hargrove, Mrs. E. R. McMurray, Mrs. C. H. Murphy, Bartow; Mrs. Stephen Gyland, Brewster; Mrs. P. W. Besenbruch, Davenport; Mrs. J. R. Boulware, Jr., Mrs. R. L. Cline, Mrs. J. D. Griffin, Mrs. J. G. Lester, Mrs. S. F. Smith, Mrs. Walter A. Weed, Mrs. J. F. Wilson, Lakeland; Mrs. B. Y. Pennington, Lake Wales; Mrs. V. H. Ragsdale, Pierce; Mrs. R. E. Gilbert, Mrs. F. E. Irons, Mrs. W. E. Sherman, Mrs. W. T. Simpson, Winter Haven.

Visitors were: Mrs. E. L. Williams, Ft. Meade; Mrs. A. J. Harness, Lakeland; Mrs. B. D. Epling, Mrs. R. E. Wilhoyt, Lake Wales; Mrs. O. R. Alexander, Winter Haven.

* * *

PINELLAS COUNTY

Members of the auxiliary of the Pinellas County Medical Society elected Mrs. John A. Herring as president of the meeting held April 12th at the Lion's Beach club at Madiera Beach. The privileges of the club house were extended auxiliary members for their outing by the president, Mrs. J. A. Strickland.

Other officers elected for the ensuing year were Mrs. R. K. O'Brien, first vice-president; Mrs. O. O. Feaster, second vice-president; Mrs. J. A. Hardenbergh, secretary; Mrs. W. C. McConnell, corresponding secretary, and Mrs. C. E. Hebard, treasurer.

The members enjoyed surf bathing, a luncheon and bridge games throughout the day.

Guests present were: Mesdames T. S. Troy, Regina Aldsworth, Thomas Soules, Ester Dulin, A. S. Anderson, Margaret Garrett, Henry Lochte, Gideon Timberlake of St. Petersburg, and Mrs. M. A. Nickle, of Clearwater.

Members present were: Mesdames T. B. Echard, N. W. Gable, Jr., W. W. Harden, C. E. Hebard, J. A. Herring, F. H. Langley, Prescott LeBreton, Earl MacCordy, W. C. McConnell, A. L. Mills, W. G. Post, Jr., J. B. Quicksall, F. W. Roush, A. P. Rooper, J. A. Strickland, M. H. Stuart, Carl Williams, and LeRoy Wylie.

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An Open Letter

May 15, 1933.

Florida Medical Association,
Jacksonville, Fla.

Gentlemen:

We have your letter of May 9th and certainly wish to thank you for the courtesies extended to our representatives at the Florida State Medical Association convention.

For the past thirty-three years we have been giving our time exclusively to the study of the needs of the medical profession. We have secured as our medical director, Dr. Claude P. Brown of Temple University, and have placed at the head of our Research Department, Dr. D. H. Bergey who was Professor of Bacteriology and Hygiene at the University of Pennsylvania for over a quarter of a century, in fact until he came with us. He first came on part time but last August resigned his position with the University and now puts in full time with us.

You may also know that Mr. H. K. Mulford, the first manufacturer of Diphtheria Antitoxin in America, has charge of our Biological Department.

We hope it may be possible for you to visit us some time in the future, and if so, it would be a great pleasure to take you to our different plants where you will have the opportunity of seeing the work that we are doing. June is a splendid month to come North and you will have the advantage of being able to visit the country and see it at its best.

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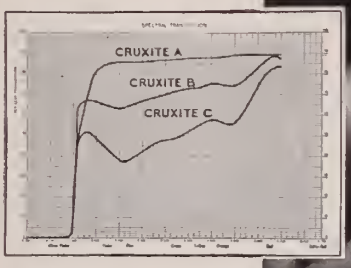
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COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	J. Maxey Dell, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	55%
Bay						17%
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		60%
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	90%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	41%
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	72%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	60%
Hillsboro	C. W. Bartlett, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	73%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	56%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	82%
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	88%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	61%
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel Bradenton	Yes.	46%
Marion	J. L. Chalker, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	62%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	Louis Orr, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	73%
Palm Beach	James L. Carlisle, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	89%
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	67%
Pinellas	Alvin L. Mills, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	76%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	83%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	34%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	91%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	100%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	92%
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital Sanford		100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	71%
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	52%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.

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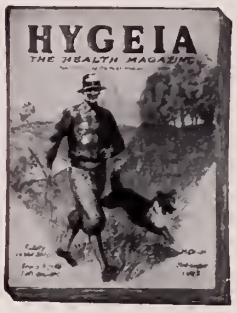
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